



PacificSource Community Health Plans, Inc.
 2965 NE Conners Avenue, Bend OR 97701
 541.385.5315 888.863.3637
 Medicare.PacificSource.com

CREDIT CARD PREMIUM PAYMENT FORM

Please fax this form to: PacificSource Medicare Sales Department Fax: (541) 382-3407

Date of Request	
Name on Credit Card	
Member Name	
Member's Account Number	
Mail Receipt?	
Address or PO Box number where their VISA/MC/Discover statement is mailed	
City, State and Zip Code where the VISA/MC/Discover statement is mailed	
Payment Amount	
Premium Month(s)	
Credit Card Type (Visa/MC/Discover only)	
VISA/MC/Discover Number	- - -
Expiration Date MM/YY	
Three digit V Code on the back of Visa/MC/Discover	
Name of PacificSource Medicare Representative	

For Office Use Only	
Credit Card Processed by (signature and date)	
Approved? <input type="checkbox"/>	Credit Card Approval Code#:
Rejected? <input type="checkbox"/>	Member notified: