Oticon Government Services

RACHAP Patient Payment Information

Account #: _____ Date: _____

Contact Name: _____

Veteran's Name: _____ Last 4 SS#: _____

Payment Information:

I authorize up to $ _____ for the purchase/service of _____ hearing instrument(s) and

_____ remote control/adapter to be charged to my: ☐ MasterCard ☐ Visa ☐ American Express

Credit Card #: _____ Exp Date: _____ Security Code: _____

Cardholder's Name: _____ Cardholder's Phone #: _____

Cardholder's Address: _____

_____

Signature: _____ Date: _____

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