NATIONAL ALLIANCE OF CONSUMERS AND HEALTHCARE PROFESSIONALS

6919 W. Broward Blvd. Suite 207
Plantation, Florida 33317

Administration Office:
Phone: (702) 425-5073
Fax: (800) 470-1416
admin@nachp.com

CHANGE OF PAYMENT OPTION

MEMBER NAME: ______________________________ MEMBER ID: ______________

CURRENT METHOD OF PAYMENT

☐ ACH DRAFT (Checking Account)

☐ VISA ☐ MASTERCARD ☐ DISCOVER

PLEASE CHANGE PAYMENT OPTION TO THE FOLLOWING:

(Please complete all applicable blanks legibly and SIGN AUTHORIZATION below.)

☐ **Monthly Electronic Funds Transfer (ACH DRAFT)**

Name of Depositor (as it appears on Bank Institution Records)

Account Number | Routing/Transmit Number | Name of Bank Institution | Branch

PLEASE ATTACH "VOID CHECK" WITH CHANGE FORM

☐ **Monthly Credit Card** ☐ **Visa** ☐ **Master Card** ☐ **Discover**

Card Number | Card Expiration Date | Security Code #

Name on Card (exactly as it appears on card) | Card Billing Address | City | State | Zip

AUTHORIZATION: (please sign below)

I, the undersigned, authorize the following payment option change to my account. I understand that all previous contract agreements for account debits and credit card authorizations and membership agreements remain in effect.

X ____

Signature | Please Print Name of Signature | Date

ATTACH "VOID CHECK" HERE TO FAX WITH FORM

PLEASE FAX FORM TO 1-800-470-1416