MIDDLE TENNESSEE PHARMACY SERVICES, LLC
661 EAST LANE ST.
SHELBYVIILE, TN 37160
877--684-9987
middtnps@yahoo.com

Please accept this as your authority to pay against my account each month a draft drawn by Middle Tennessee Pharmacy Services, LLC for our prescription drug bill. The amount of this draft will vary according to the amount of prescriptions. I understand that my account will be drafted on the due date as stated on the bill. This authority is to remain in full force and effect until Middle Tennessee Pharmacy Services, LLC has received written notice from me of its termination in such time and in such manner as to afford Middle Tennessee Pharmacy Services, LLC a reasonable opportunity to act on it. This information will be used by Middle Tennessee Pharmacy Services, LLC only for the processing of monthly statements and will be kept strictly confidential.

Automatic Bank Draft Authorization Form

Name:
Address:
City:
State:
Zip:
Telephone:
Patient Name:
Bank Name:
City:
State:
Zip:
ABA Transit/Routing Number:
Bank Account Number:
Account Type (Checking or Savings):

Attach a voided check to this form.
Mail this form **and a voided check** to: Middle Tennessee Pharmacy Services, LLC
661 East Lane St.
Shelbyville, TN 37160

Printed Name:_____

Signature:
_____Date:_____