MATRIX HEALTH SYSTEMS/OTTER CREEK ASSOCIATES

Please complete this form for credit card payments; once complete, please email a PDF copy to chelsea@ocamhs.com OR drop off/mail a hard copy (addressed to your provider) to 86 Lake Street, Burlington VT 05401 (VISA, MasterCard, Discover or HSA only)

Cardholder's Name: ____

Cardholder's Street Address: ____

City, State and Zipcode: ____

Email Address: ____

Cell Phone Number: ____

Credit Card Number: ____

CVV: __________

Expiration Date: ____

Amount: ____

Date of Service: ____

Patient: ____

Clinician or Program: ____

How would you like to receive your billing statements?

- ☐ Email
- ☐ Mail
- ☐ Text

For Billing Department:

Batch #: _________________________ Date: ____________