El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

CAFETERIA MEAL ACCOUNT
PHYSICIAN INFORMATION
(For New Account)

First Name: _____ Middle Name: _____

Last Name: _____

ID Badge Card Number: _____

(Note: This is the five (5) digit number below the bar code at the back of your ID Badge Card)

Physician Services (Assigned) Account Number: _____

(For Office Use Only)

Billing Address

Name of Organization: _____

Street: _____

City: _____ State: _____ Zip/Postal Code: _____

Telephone No.: _____ Extension: _____

Your account will be activated after Patient Accounting assigns an account number for you. You will receive individual statement each month.

Please write legibly. Please attach a copy of front and back of your ID Badge to this form.

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Date: ____________________

To: **ECH MV Physician Meal Stipend**

Re: Authorization for Use of American Express/Discover/MasterCard/VISA

In order for EL CAMINO HOSPITAL to charge your American Express/Discover/MasterCard/VISA credit/debit card for charges over the $15.00 per day limit and/or total allowance of $120.00 per month, the Hospital must have your written authorization on file. The Hospital must again ask for your authorization when your *current credit card expires* and is subsequently renewed.

If you wish to authorize EL CAMINO HOSPITAL to automatically charge your credit card for the above, please complete the information below.

For the Account of: ______________________________
Physician Name

Please select the type of credit card:

☐ AMERICAN EXPRESS

_ _ _ _   _ _ _ _ _ _   _ _ _ _ _   ___/___ ***Expiration Date***   _ _ _ _ ***CVV / CVC #***

☐ DISCOVER ☐ MasterCard ☐ VISA

_ _ _ _   _ _ _ _   _ _ _ _   _ _ _ _   ___/___ ***Expiration Date***   _ _ _ ***CVV / CVC #***

Cardholder's Complete Billing Information:

____
Printed Name (as it appears on card)

____
Street Address

____________________, ________ ____________
City ***State*** ***Zip Code***

(   ) ____________________ ______________________________
Phone Number ***Email Address***

I authorize EL CAMINO HOSPITAL to charge my credit card/debit card for any MV meal stipend overages. I may revoke this authorization at any time.

______________________________ ______________
Authorized Signature ***Date***