

MEDICARE Accreditation Assistant Order Form

Mail or FAX this form to:

AAAASF

P.O. Box 9500

Gurnee, IL 60031

FAX Orders: **847-775-1985** Or scan and email to reception@aaaasf.org

To order from AAAASF, complete this form and fax or mail with your check or credit card payment to the address above.



Quantity Price Total

_____ @\$950.00 _____

TOTAL: \$ _____

Facility Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

You must provide written authorization to charge and signature of cardholder.
For credit card payment, circle type of card:

Card number: _____

Expiration date: _____

Please print name as it appears on the card.

Cardholder's signature:

Circle method of payment:

Check Visa MasterCard American Express

Total enclosed or authorized amount to charge to credit card \$ _____