Donor Form with Credit Card Information

Type of Card (circle one):

Master Card Visa Discover American Express

Card Number: _____

Expiration Date: _____ **Security Code**(3 or 4 digits) _____

Amount: $_____

Billing information

Name as it reads on the card: _____

Billing Address:
Street or P.O. Box: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Email: _____

Please mail to:
Kym Taflinger
Special Projects Director
Health Partners of Western Ohio
441 East 8th Street
Lima, OH 45804
phone: 419-221-3072
fax: 419-225-8095

Thank you for your donation to Health Partners of Western Ohio as we continue to care for those with limited health care access.