Soteria Healthcare Network
PRIMARY PAYOR INFORMATION FORM

Alpharetta, GA USA
Got Questions: +770 455 8190 x 119

MEMBER NAME: _____

TELEPHONE/CELL/Office: _____

Kaiser Member ID: _____

Date of Birth: _____ / _____ / _____

Are You A Dependent of A Kaiser Permanente Plan Member? (Circle One) YES | NO

Are You Covered By Any Other Medical Insurance Coverage? (Circle One) YES | NO
If Yes, Please Provide The Information Below

- Name of Insurance Co. _____
- Policy/Group #. _____
- Phone # _____

IF NO, PLEASE READ THE STATEMENT BELOW AND SIGN.

I attest that I have no other medical insurance coverage other than Kaiser Permanente Health Plan of Georgia.

_____ _____ / _____ / _____
SIGNATURE DATE

Please fax this page along with Chiropractic Treatment Plan Form To: Soteria Healthcare ... Fax #: 404-341-9804

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