Soteria Healthcare Network

Primary Payor Information Form

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Alpharetta, GA USA
Got Questions: 770-455-8190, ext. 119

Please Print. Must be legible or will be returned without authorization.

Member Name (**As It Appears On Card)**:____

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 # ____

PLEASE READ THE STATEMENT BELOW AND SIGN.

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

_____________________________________ _________/_________/______________

SIGNATURE **DATE**

Please fax this along with the Chiropractic Treatment Plan Form to: Fax: 404-341-9804