PATIENT/MEMBER INSTRUCTIONS:
This form is to be completed/filled out by patient/member upon first visit each calendar year & returned to Soteria Healthcare Network, Inc.

Primary Payor Information Form

CHIROPRACTIC OFFICE INSTRUCTIONS:
Please have the Patient/Member complete this form ON THEIR FIRST VISIT OF THE CALENDAR YEAR OR, IF THE MEMBER/PATIENT EMPLOYER and/or HEALTH INSURANCE HAS CHANGED. Please submit to Soteria Healthcare Network at fax 404-341-9804. Any questions/comments, please call 770-455-8190 ext 119.

Please complete the following information AS IT APPEARS ON THE CARD

Member Last Name: ________________________ Member First Name: ________________________

Member Tel.____________________________ Member Date of Birth:_________________________

Kaiser Permanente Member ID: ____

Are you a dependent of a Kaiser Permanente Plan Member? (Yes/No) ___ Yes ___ No

Are you covered by any other medical insurance coverage? (Yes/No) ___ Yes ___ No

If yes, please provide the information ...

Name of Insurance Company: ____

Policy/Group #: _____________________________ Tel. _____________________________________

Member Signature ______________________________________ Today's Date __________________

OFFICE INSTRUCTIONS

Once signed and completed, please fax this document to fax # 404-341-9804.

Copies of this form can also be downloaded/available at www.SoteriaHealthcare.com/downloads