Date Extension Request Form

CHIROPRACTIC OFFICE INSTRUCTIONS:
Please complete and return to Soteria Healthcare Network.
As always, if you have any questions/comments, please call 770-455-8190 ext 119.

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

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Please complete the following information and return to your friends @ Soteria Healthcare!

Patient Last Name: ______________________________ Patient First Name: ______________________________

Patient Member # er ____

Authorization # er ____

Date Parameters of Authorization Effective Date __________________ End Date ______________________________

Visits Authorized __________________________________ Visits Used __________________________________

Reason for Date Extension Request/Comments

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Treating Doctor (Printed Full Name) ____

Treating Doctor (Signature) ____

Today's Date ____