YMCA Club Membership Form

Email filled out form to: **ExtraBenefitsGeorgia@caresource.com**

ONE FORM PER FAMILY

Who should fill out this section? The member or Member's parent or guardian. *Please print.*

Member's Name: _____

Street: _____

City: _____ State: _____ County: _____

Phone Number: _____ Email: _____

ID number: _____ Date of Birth: _____/____/_____

Club you want to join:

Club's Street: _____

City: _____ State: _____

Who should fill out this section? The provider or provider's office must fill out this section. * *Please print.*

Dental Provider Name: _____ NPI Number: _____

Office Street: _____

City: _____ State: _____ County: _____

Provider Signature or Stamp: _____

Wellness Provider Name: _____ NPI Number: _____

Office Street: _____

City: _____ State: _____ County: _____

Provider Signature or Stamp: _____

Care Given:

Medical:

☐ Well Visit Date:_____

☐ Prenatal Visit Date:_____

☐ Postpartum Visit Date:_____

Dental:

☐ Exam Date:_____

THANK YOU!