Club Membership Form

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

ONE FORM PER FAMILY

Member or Member's parent/guardian must fill out this section. 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: _____

THIS SECTION MUST BE FILLED OUT BY THE PROVIDER/PROVIDER'S OFFICE
Please print.

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