DOCTOR LIST

I authorize Tracy Thomas CSA, an agent with Sovereign Seniors LLC, to call me regarding coverage options and understand that I am volunteering this medical information.

Name: _____ Phone: _____

Signature: _____ Date: _____

Important instructions: Please complete this form in its entirety. Include all doctors you visit or may see. Use one sheet per household member. The bold box on the right is for our office use.

Preferred Hospital: _____

Primary Care Physician:

Full name: _____ Are you willing to change this Dr.? Y N

Street office is on: _____ City, state: _____

Phone Number: _____

Additional Doctor:

Full name: _____ Are you willing to change this Dr.? Y N

Street office is on: _____ City, state: _____

Phone Number: _____

Additional Doctor:

Full name: _____ Are you willing to change this Dr.? Y N

Street office is on: _____ City, state: _____

Phone Number: _____

Additional Doctor:

Full name: _____ Are you willing to change this Dr.? Y N

Street office is on: _____ City, state: _____

Phone Number: _____

Additional Doctor:

Full name: _____ Are you willing to change this Dr.? Y N

Street office is on: _____ City, state: _____

Phone Number: _____

Date checked:

_____

If you have more doctors, write them on the back and check this box [ ]

Please return this doctor list, your medication list and Scope of Appointment form to:

Mail: Sovereign Seniors LLC
119 Evergreen Rd. #43311
Louisville, KY 40243
Attn: Tracy Thomas, CSA

Fax: (502) 333-0511
Phone: (502) 215-0881