ELIGIBILITY CERTIFICATION

SUBSCRIBER'S

NAME: ____

INSURANCE: ____

ID #: ____

"I, ______________________________, understand that I am eligible for insurance benefits on or as of ______________ (Date). I understand that ___________________________is the medical group/Insurance chosen for all members of the contact under which I am covered, I am aware that if the above is not true, I(or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me) will pay in full all such charges."

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SIGATURE OF PATIENT OR RESPOSIBLE PARTY