ELIGIBILITY GUARANTEE

I, _____ (Subscriber's Name), understand that I am eligible for Health Plan Benefits with _____ (Name of Health Plan) as of _____ (Month) _____ (Day), _____ (Year). through _____ (Name of Employer Group). I have selected _____ (Name of Medical Group) as my Medical Group, Dr. _____ (Physician Name) as my medical provider. I understand that if the above is not true, or if I am ***not eligible*** under the terms of my Health Plan and/or employer group's Medical and Hospital Subscriber Agreement, I am ***financially responsible*** for all charges for services rendered. Additionally, and assuming my eligibility for benefits is not established as set forth above, I agree to pay for all services within 60 days of receiving a bill from the physician listed above.

_____ (Signature) _____ (Date)

_____ (Witness) _____ (Date)

Patient's Name: _____ DOB: _____

Member ID Number or Subscriber's Social Security Number: _____

Eligibility Verified by:

_____ (Eligibility Representative or Physician Staff) _____ (Site)

_____ (Member Service Rep or Voice Response Unit) _____ (Confirmation Number)

Member Verified? ❑ Yes ❑ No

Employer Group Verified? ❑ Yes ❑ No