ELIGIBILITY CERTIFICATION

Patient(s) Name: 1. _____ DOB: _____

2. _____ DOB: _____

3. _____ DOB: _____

4. _____ DOB: _____

Subscriber's Name: _____ SSN: _____

Employer: _____

Insurance Company: _____

Primary Care Physician: _____

Medical Group / IPA: _____

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.

Signature of Responsible Party: _____ Date: _____

Please initial next to the current month

Year: _____

Jan: _____	May: _____	Sep: _____
Feb: _____	Jun: _____	Oct: _____
Mar: _____	Jul: _____	Nov: _____
Apr: _____	Aug: _____	Dec: _____