ELIGIBILITY CERTIFICATION

HMO PATIENTS

SUBSCRIBER INFORMATION		
SUBSCRIBER NAME	PATIENT NAME	
RELATIONSHIP TO SUBSCRIBER	INSURANCE COMPANY NAME	GROUP #
CERTIFICATION / SOCIAL SECURITY #	MEMBER NUMBER	

"I, ________________________________, understand that I am eligible
(NAME OF PATIENT)

for ____________________ benefits on or as of __________ through my
(INSURANCE CO. NAME) (EFFECTIVE DATE)

___________________ employment at ____________________________,
(OWN/SPOUSE'S/PARENT'S) (NAME OF EMPLOYER)

or through my ________________________________ HMO policy."
(OWN/SPOUSE'S/PARENT'S)

"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 PATIENT OR RESPONSIBLE PARTY	OFFICE PERSONNEL	DATE