

Medical Group of North County, Inc.



ELIGIBILITY GUARANTEE FORM

I, _____ hereby certify that on _____, I am
Name of Patient/Member or Guardian Today's Date
eligible for _____ through _____,
Name of Insurance Plan Employer Group
_____. I have chosen
_____.
Name of Subscriber IPA/Medical Group/Physician
to be my Medical Provider.

I understand that if the above is not true or if it is determined that I am not eligible under the terms of my employer's Medical Insurance Plan; I am liable for all charges for services rendered.

Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from the Medical Group of North County, Inc.

Signature of Member (or Guardian)

Patient Name: _____

Patient Birth Date: _____

Patient Address: _____

Home Telephone #: _____

Subscriber Name: _____

Subscriber Social Security #: _____