JAPAN TOWN MEDICAL GROUP

FAMILY PRACTICE & SPORTS MEDICINE

Eligibility Guarantee Form

I, ____ hereby certify

That I am eligible for ____

(Name of Health Plan) Effective Date

____

Name of Subscriber Subscriber Employer

I have chosen Dr. _________________________ to be my Primary Care Physician. I understand that if the above is not true or if I am not eligible under the terms of my employer's Medical Hospital Agreement, I am liable for all services rendered and I agree to pay in full for such services.

____

Signature of Member/Guardian Date

For Office Use

Eligibility Verified by:

____

____

Name if IPA/PMG **Date**

____

Office Personnel Verifying Eligibility **Date**