Simi Medical Group, Inc.

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Eligibility Guarantee Form

_____ , understand that I am eligible for
(Patient Name)

_____Insurance benefits on or as of: _____
(name of HMO) (effective date)

Through my: ☐ OWN ☐ SPOUSE ☐ PARENT'S EMPLOYMENT AT:

_____
Name of employer

I have chosen SIMI MEDICAL GROUP of Simi Valley to be my primary medical group.

I understand that if the above is not true or if I am not eligible under the terms of my employer's Medical Subscriber Agreement, 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 for all such charges.

Subscriber's Name: Subscriber's Date of Birth:

Signature of patient (or Responsible Party) Today's Date:

Signature of Office Personnel: Date Signed: