SOUTH COAST FAMILY
MEDI-CENTER

ELIGIBILITY WAIVER FORM

SUBSCRIBER'S NAME_____

PATIENT'S NAME_____

ADDRESS_____

_____

HOME PHONE(_____)_____-_____
WORK PHONE(_____)_____-_____

PHYSICIAN RENDERING SERVICES_____

I hereby certify that I am eligible with:

NAME OF INSURANCE COMPANY_____

SINCE (EFFECTIVE DATE)_____

THROUGH (EMPLOYER)_____

I understand that if the above is not true or if I am not eligible under the terms of my employer's medical and subscriber agreement, 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 thirty (30) days of receiving a bill from the above physician. I also understand that it is my responsibility to know what services will be covered under my policy.

_____ _____ _____

NAME (PLEASE PRINT) SIGNATURE DATE