ELIGIBILITY CERTIFICATION

I, _____, UNDERSTAND THAT I AM ELGIBLE FOR
(Name of Patient)

_____BENEFITS ON OR AS OF _____ THROUGH MY
(Name of Insurance) (Effective Date)

_____ EMPLOYMENT AT _____.
(Own/Spouse's/Parent's) (Name of Employer)

I UNDERSTAND THAT **FAMILY PRACTICE MEDICAL GROUP of SAN BERNARDINO (FPMG)** IS THE MEDICAL GROUP FOR ALL MEMBERS OF THE CONTRACT UNDER WHICH I AM COVERED. 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 THE SERVICES PROVIDED TO ME. I ALSO UNDERSTAND AND 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 Date

_____ _____ _____
Subscriber's Name Certificate Number Group Number

For Office Use ONLY

ELIGIBILITY VERIFIED BY:

_____ _____ MEMBER VERIFIED ☐ Yes ☐ No
Name of Coordinator Date

_____ _____ EMPLOYER VERIFIED ☐ Yes ☐ No
Member Services Representative Date