Physicians Medical Group

EXCEL MSO, LLC
Pathway to Success

Eligibility Waiver Form (Letter of Guarantee)

As a condition of receiving health care from the Provider listed below, I (the Patient, parent, legal guardian, or subscriber) hereby attest that the Patient is an "Eligible" member of _____ (Health Plan Name) Health Plan as of this date of service. I further hereby attest that should the Patient later be determined "ineligible" for the services rendered by this Provider, I understand that I will be billed and held financially responsible for these services, and I agree to comply with demands for payment by the Provider.

Date_____ Provider's Name: _____

_____
Patient's Full Name

_____ _____
Patient's Date of Birth Patient's Telephone Number

_____
Subscriber's Member ID Number

_____
Signature (*Patient or Responsible Party)*

FOR OFFICE USE ONLY

Verification of eligibility was requested by: _____

Eligibility was verified by: _____ _____
(Name of HMO Representative) Date

Member/Subscriber Effective Date: _____