



### 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*)

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#### FOR OFFICE USE ONLY

Verification of eligibility was requested by: \_\_\_\_\_

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

Member/Subscriber Effective Date: \_\_\_\_\_

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