

Eligibility Guarantee Form

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

_____ insurance benefits on or as of
(Insurance Company)

_____ through my: own spouse's employment
(Effective Date) (circle one)

(Name of Employer)

I have chosen _____ to be my primary medical group.
(Name of Medical Group)

.....

I understand that if the above is not true, or I am not eligible, or covered under the above-indicated insurance plan, I am responsible for all charges related to services provided to me.

In addition, I understand that all services performed at FSMAC require prior authorization from my Primary Medical Group. After initial consultation authorization, FSMAC will request authorization for future treatment as indicated by the physician. **However, it is ultimately my responsibility to ensure authorization has been received prior to any treatment being rendered.** If prior authorization is not obtained and I received medical treatment, I will be financially responsible for all incurred charges.

Patient's Name **Date:** _____

Patient's Signature

Signature of Office Personnel