code: GF001

Eligibility Waiver

Subscriber's Full Name _____ **Subscriber's Social Security Number** _____ **Subscriber's Date of Birth** _____

I (The Above Named Person) hereby certify that I am eligible for benefits effective:

Effective Date:

_____

For Patient:

First Name _____ **Middle Name / MI** _____ **Last Name** _____

I have chosen **{Physician Name}** to be my medical provider.

I understand if the above is not true, I am responsible for all charges related to services provided to me. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from **{Provider's Office}**.

Date

_____

Signature of Patient or Responsible Party: