

Health Plan Eligibility Certification Form

South East Bay Pediatric Medical Group
2191 Mowry Ave., Ste. 600C, Fremont CA 94538
Ph. (510) 792-4373 Fax (510) 792-3420

Dear Parent:

Your signature on this form acknowledges that you agree to accept full financial responsibility for all services provided by South East Bay Pediatric Medical Group as listed below if the following applies:

- ▶ your child is determined NOT to be eligible for coverage with your health plan
- ▶ the services provided are NOT covered by your health plan
- ▶ we are NOT the assigned Primary Care Physician by your insurance carrier.

I, _____ understand that I and/or
(Name of Patient or Responsible Party)

my child is/are eligible for benefits from _____
(Health Plan / Insurance Carrier Name)

as of _____.
(Effective Date)

I am aware that if the above is not accurate, I (or the person financially responsible for me) will be responsible for all services rendered to me or my child by South East Bay Pediatric Medical Group.

(Signature of Patient or Responsible Party)

(Name)

(Date)