

BRISTOL PARK
MEDICAL GROUP

ELIGIBILITY CERTIFICATION
HMO PATIENTS ONLY

SUBSCRIBER INFORMATION		
SUBSCRIBER NAME	PATIENT NAME	
RELATIONSHIP TO SUBSCRIBER	INSURANCE COMPANY NAME	GROUP #
CERTIFICATION/SOCIAL SECURITY #	MEMBER NUMBER	

“I, _____, understand that I am eligible
(NAME OF PATIENT)

for _____ benefits on or as of _____ through my
(INSURANCE CO. NAME) (EFFECTIVE DATE)

_____ employment at _____,
(OWN/SPOUSE'S/PARENT'S) (NAME OF EMPLOYER)

or through my _____ HMO policy.”
(OWN/SPOUSE'S/PARENT'S)

“I understand that Bristol Park Medical Group, Inc. is the IPA/Medical Group chosen for the above named patient.”

“I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me) will pay in full all such charges.”

NOTE: For services to be covered, the medical group on the card must be Bristol Park Medical Group.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	OFFICE PERSONNEL	DATE
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