ELIGIBILITY GUARANTEE FORM

I, _____, hereby certify I am eligible for medical
Patient Name
benefits/coverage with _____ insurance company.

If this carrier is an HMO, it is processed through:

- ☐ Sharp Community Medical Group (SCMG)
- ☐ Sharp Rees-Stealy (SRS)
- ☐ Mercy Physician Medical Group (MPMG)
- ☐ Scripps Coastal Medical Group
- ☐ Scripps Clinic Medical Group
- ☐ San Diego Physicians Medical Group
- ☐ Other_____

I understand if I change my PCP, this will likely change the IPA (Independent Practice Association) I am affiliated with and I will therefore notify NMC of this change immediately.

Neurosurgical Medical Clinic, Inc. shall consider eligibility with both the insurance company listed above as well as the indicated IPA, in effect until written notice with policy termination date is given by me. Furthermore I understand I am ultimately responsible for all charges incurred, and any authorization, referral or pre-certification that may be issued by my insurance carrier and/or IPA is not a guarantee of payment by them. If any claim is denied, I understand payment is immediately due and payable by me.

I understand the contents of this form and certify the above information is correct.

_____ _____
Date Signature

If not signed by the patient, please indicate relationship:

□ guardian □ personal representative □ conservator

Name of Patient:_____

A copy of this form will be given to me upon my request