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)

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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 BHF require prior authorization from my Primary Medical Group. After initial consultation authorization, BHF 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.

____ **Date:** ___________________

Patient's Name

____

Patient's Signature

____

Signature of Office Personnel