Pacific Shores MEDICAL GROUP
Hematology · Oncology · Infusion Services
www.pacshoresoncology.com

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Eligibility Waiver Form

I, _____hereby certify that I am insured by the following Insurance/Medical Group_____ and that my benefits are effective as of the following date_____.

I understand that if the above information is not true or if my insurance benefits change and I fail to notify Pacific Shores Medical Group about such change prior to medical services being rendered to _____(Your Name), I shall be responsible for all charges related to these services.*****

_____

Signature of Patient or Responsible Party Date

_____

Subscriber Social Security Number Subscriber Name

_____

Account Number Patient Name

***Please note that we bill your Insurance as a courtesy.**