



SOUTHERN ORANGE COUNTY PEDIATRIC ASSOCIATES

"Great Care for Great Kids"

ELIGIBILITY GUARANTEE

I, _____, hereby
certify that my child, _____,
is eligible for benefits from (Insurance Company) _____
as of (Effective Date)_____.

HMO PPO (circle one)

I.D. Number _____

Group Number _____

I have chosen Dr. _____

as the provider for my child's health care needs. I understand that if my child is not eligible, I am responsible for all charges incurred in the delivery of medical services and will be required to pay for those charges within 30 days of billing.

(Signature of Parent or Guardian)

(Date)

(Witness)

(Date)