



Southern Orange County Pediatric Associates

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. # _____

Group # _____

I have chosen Dr. _____ as the provider for my
child's healthcare 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)