MONARCH HEALTHCARE
ELIGIBILITY WAIVER

PATIENT NAME:	HEALTH PLAN:
ID NUMBER :	EFFECTIVE DATE:
PHYSICIAN NAME:	

The Patient or Patient's Legal Representative hereby certifies that he/she is eligible for health plan benefits coverage, and has chosen the above stated physician as the provider of his/ her healthcare.

Furthermore, the Patient or Patient's Legal Representative understands that if he/she is found ineligible for coverage of plan benefits, he/she is financially responsible for all cost incurred during the delivery of health services, and agrees to pay these charges to the physician accordingly.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Witness Date