ELIGIBILITY GUARANTEE/ASSIGNMENT OF BENEFITS FORM

l,	, hereby certify that I am eligible for chiropractic benefits
(Name of Patient/Member/Guardian)	. , , , , , , , , , , , , , , , , , , ,
offered by(Name of Health Plan)	as of (Today's Date)
Policy, I am liable for all charges for service	not true, or if I am not eligible under the terms of my Insurance ces rendered. Also, if the above is not true, I agree to pay in full days of receiving a bill from the above Chiropractor or Health Plan
Assignment of Benefits:	
I authorize the release of any hea this authorization shall be effective and va	alth information necessary to process this claim. A photocopy of alid as the original.
I authorize payment of medical be through his/her contract with above listed	enefits to the Chiropractor listed above who accepts assignment health plan.
payment, other than the applicable co-pay	r will not bill me for any charges over and above the insurance yments, co-insurance or deductible, since the Chiropractor has I Insurance Company to waive all unpaid fees.
(Date)	(Signature of Member or Subscriber)