

**PULMONARY CONSULTANTS & PRIMARY CARE PHYSICIANS
MEDICAL GROUP, INC.**

ELIGIBILITY CERTIFICATION

Patient's Name: _____

Subscriber's Name: _____ Social Security #: _____

Employer: _____

Insurance Company: _____

Primary Care Physician: _____

Medical Group/IPA: _____

I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me) will pay in full all such charges.

Signature of Responsible Party: _____ Date: _____