Women's
Health Partnership Medical Group
EXCELLENT CARE FOR EVERY SEASON OF LIFE

TWO CONVENIENT LOCATIONS:
168 North Brent Street, Suite 407
Ventura, CA 93003
(Across from Community Memorial Hospital)
110 West Harvard Boulevard, Suite D
Santa Paula, CA 93060
(805) 648-2717 • www.WomensHealthMedGroup.com

WAIVER FORM

DATE	PROVIDER NAME (Physician)	HEALTH PLAN

As a condition of servicing the health care needs of the below-listed patient, I hereby attest that the patient is an "eligible" member of the Health Plan indicated as of this date of service. I further hereby attest and agree that should the patient later be determined "ineligible" for the services rendered by this provider, I shall comply with demands of payment to the provider of monies (not to exceed actual service costs) deemed by the plan to be compensation for said rendered services.

PATIENT'S NAME ______________________________

SUBSCRIBER'S NAME ______________________________

PATIENT DATE OF BIRTH ______________________________

INSURANCE I.D. NUMBER ______________________________

ADDRESS ______________________________

____

TELEPHONE ______________________________

EMPLOYER NAME AND ADDRESS ______________________________

____

SIGNATURE ______________________________