Valley Wound Healing Center

1317 Oakdale Road #440

Modesto, Ca. 95355

(209) 342-5125

Eligibility Verification

_____ is eligible for medical benefits as of _____ through my

Patient Name Effective Date

_____at _____.

Self/Spouse/Parent Name of employer

I understand that Valley Wound Healing Center is the medical facility I have selected through my medical insurance with:

_____.

Name of Insurance Company

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

_____

Patient/Responsible Party Signature

_____

Date

_____

Insurance ID#

_____

Insurance Group#