

# TEMPORARY MEMBERSHIP ID FORM

## FOR COPAY, DEDUCTIBLE, AND IN-NETWORK PORTION OF POS PLANS

Complete and detach this page to use as your Temporary Membership ID.

**Important:** Check the box for the plan your group has selected.

You can receive care at our facilities any time after your coverage becomes effective. Simply take this form, along with a copy of your enrollment form and a picture ID, and present it to the receptionist.

My group has selected the following plan:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> \$50 Copayment Plan | <input type="checkbox"/> \$30/\$2,700 Deductible Plan with HSA | <input type="checkbox"/> \$30/\$1,500 Deductible Plan          |
| <input type="checkbox"/> \$30 Copayment Plan | <input type="checkbox"/> \$0/\$2,700 Deductible Plan with HSA  | <input type="checkbox"/> \$30/\$1,000 Deductible Plan          |
| <input type="checkbox"/> \$20 Copayment Plan | <input type="checkbox"/> \$0/\$2,200 Deductible Plan with HSA  | <input type="checkbox"/> \$30/\$2,500 Deductible Plan with HRA |
| <input type="checkbox"/> \$15 Copayment Plan | <input type="checkbox"/> \$0/\$1,500 Deductible Plan with HSA  | <input type="checkbox"/> \$30/\$1,500 Deductible Plan with HRA |
| <input type="checkbox"/> \$5 Copayment Plan  |  | <input type="checkbox"/> \$35 POS Plan (in-network)            |

Group number

Enrollment unit

Effective date of coverage

Company name

Subscriber name

Social Security number

Date of birth (MM/DD/YY)

Medical record number (if known)

Spouse/Domestic partner

Dependent

Dependent

Dependent

Dependent

**X**

Subscriber signature (**Sign in black ink only.**)

**Note to receptionist:** If more information is needed, please ask patient to complete a *Member Eligibility Information Form*. For questions concerning a patient's eligibility, contact the California Service Center at tie-line **8-279-5320**.

