Mail to: Sierra Health Group, LLC
440 Franklin Street, Suite 300
Bloomfield, NJ 07003

Fax to: 888-420-7704

Virtua Health

SPOUSE / OTHER RESPONSIBLE PARTY CERTIFICATIONS

Patient name: _____ Date: _____

Responsible party name: _____ Relationship: _____

Account #: _____ Date of service: _____

Please place initials to the left of all applicable attestations.

____ I attest that I had **no income** for _____ months prior to the date of service.

____ I attest that I had **no assets** at the date of service or for _____ months prior.

____ I attest that I have **no medical insurance** through myself or any other party to cover the outstanding balance for services rendered to the patient on _____ .

____ I attest that all information provided here is true and correct to the best of my knowledge.

____ I hereby refuse to provide any information.

Signature: _____ Date: _____