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 Cerritos, CA 90703
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Eligibility Research Request

Date: _____ **PCP:** _____

Contact: _____ **Phone:** _____ **Fax:** _____

The following members are effective per the health plan, but are not showing on my capitation list. Please research and verify that the patients are eligible.

Member Information: (Please print CLEARLY. ALL INFORMATION MUST BE COMPLETED):

Member Name	Date of Birth	Health Plan	Member ID #	Months Cap Not Received
1.				
IPA USE ONLY:	Effective Date:		Comments:	
2.				
IPA USE ONLY:	Effective Date:		Comments:	
3.				
IPA USE ONLY:	Effective Date:		Comments:	
4.				
IPA USE ONLY:	Effective Date:		Comments:	
5.				
IPA USE ONLY:	Effective Date:		Comments:	
6.				
IPA USE ONLY:	Effective Date:		Comments:	
7.				
IPA USE ONLY:	Effective Date:		Comments:	
8.				
IPA USE ONLY:	Effective Date:		Comments:	
9.				
IPA USE ONLY:	Effective Date:		Comments:	
10.				
IPA USE ONLY:	Effective Date:		Comments:	

FAX REQUEST TO: (562) 924-1603 ATTN: PROVIDER RELATIONS

**Note: Once eligibility has been verified, capitation will be paid retroactive 3 months from date of notification.*