ADVANTAGE HEALTH NETWORK IPA • ALLIED PHYSICIANS IPA
GREATER ORANGE IPA • GREATER SAN GABRIEL VALLEY PHYSICIANS IPA

ELIGIBILITY REQUEST FORM

Please fill in this form for eligibility inquiry.
Photocopies of the member's insurance card, health plans web site eligibility print out or any other supporting information will help expedite the process.

Please fax to: (626) 943-6373

Date: _____ Provider's Name: _____

Provider's Office Contact Person: _____ Provider's Office Contact Number: _____

Provider Fax number: _____ Email: _____

*Member's eligibility status will be verified and returned through fax or email

Last Name	First Name	DOB	Member ID #	Health Plan	Line of Business:	Gender	Address: (Must input for correct authorization)	Phone #	Membership Effect Date
					MCAL POS Commercial Senior Healthy Families				
					MCAL POS Commercial Senior Healthy Families				
					MCAL POS Commercial Senior Healthy Families				

Notice - Any incomplete information may cause delay to process the request.
Thank you for your support and assistance. Should you have further questions, please contact Eligibility at **(626) 943-6179**.