Saint Michael's
MEDICAL CENTER
A MEMBER OF CATHOLIC HEALTH EAST

Patient Account # _____

I, _____ certify that, on the date of service at Our Lady of
Patient Name

Lourdes Medical, which occurred on , _____ I was a resident of New Jersey.

Further, I have no residency in any other state and it is my intent to remain a resident of New Jersey.

Do you have any insurance coverage? YES NO

Name of Insurance _____

_____

Signature of Patient or Responsible Party Date