Guarantor (Financially Responsible Party) Update Request Form

This form serves as a request to update the guarantor, also known as the financially responsible party, for the patients specified in this form.

In the case that the financial responsibility for the patients identified in this form is legally divided between multiple parties, one of which is the current guarantor associated with the patient(s) identified below, we will be unable to change the current guarantor associated with the patient(s). The following are examples of accepted documents that can be used to demonstrate the financial responsibility of the updated guarantor:

- Divorce decree indicating 100% financial responsibility for medical bills to the individual identified below as the updated guarantor.
- Notarized court document in indicating 100% financial responsibility for medical bills to the individual identified below as the updated guarantor.

Upon approval of the supporting documentation, the below request will be applied to all visits following the effective dates of the document.

Current guarantor information:
Guarantor ID: ___________________________________
Guarantor Name:__________________________________
Relationship to Patient: ____________________________
Address: ____
City/State/Zip: ____________________________________
Home Phone Number: ____________________________
Cell Phone Number: ______________________________
Work Phone Number: _____________________________

Guarantor information that I am requesting the above be updated to reflect:
Guarantor Name: ___________________________________
Relationship to Patient: ______________________________
Address: ____
City/State/Zip: _____________________________________
Home Phone Number: ______________________________
Cell Phone Number: ________________________________
Work Phone Number: _______________________________

Please provide information for patient(s) affected:

Patient Name	Patient DOB	Patient MRN #

I, ____________________________________ , am accepting full financial responsibility of all medical expenses for __________________________________ , who is the current guarantor as recognized by Rady Children's Hospital of San Diego, and am requesting all outstanding balances be billed to the updated address provided above.

____ ______________

Signature of Parent/Guardian Accepting Financial Responsibility Date

____ ______________

Signature of Current Guarantor Date

Please enclose a copy of this completed form to:

Rady Children's Hospital
PO Box 843929
Los Angeles, CA 90084-3929

Upon receipt of this form, please allow 5-7 business days for review and any updates to be made in our system. In the case that we are unable to update the guarantor for the patients identified, we will contact you to inform you of this decision.