

Client Information Form

1. CLIENT

The client is the person who will be receiving the equipment or services

Client Name (Last, First, MI):		Client Date of Birth:	
Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other <input type="checkbox"/> Employed	<input type="checkbox"/> Full-Time Student	<input type="checkbox"/> Part-Time Student
Sex:	<input type="checkbox"/> male <input type="checkbox"/> Female	Social Security Number:	
Currently own a communication device?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Make/Model:	Date of purchase:
Current place of residence: (check all that apply)	<input type="checkbox"/> Home <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Custodial Facility (assisted living)	<input type="checkbox"/> Intermediate Care Facility/Mentally Retarded Facility	<input type="checkbox"/> In Hospice Program
Address:		Name of Facility:	
City:	State:	Zip:	County:
Home Phone:	Work Phone:		Fax:

2. CONTACT / CLIENT ADVOCATE The contact person is the person who is assisting the client, or is the emergency contact

Name:		E-Mail:	
Address:			
Relationship to Client:	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other (please specify)		
City:	State:	Zip:	
Phone:	Alternate Phone:	Fax:	

3. SPEECH LANGUAGE PATHOLOGIST The SLP is the clinician that performed the evaluation of the client and provided the written report

Name:		E-Mail:	
Address:			
City:	State:	Zip:	
Phone:	Alternate Phone:	Fax:	
ASHA Number:	State License Number:		

4. TREATING PHYSICIAN The treating physician is the medical doctor who has prescribed the requested equipment

Name:		NPI (National provider Indicator):	
Address:			
City:	State:	Zip:	
Work Phone:	Alternate Phone:	Fax:	
Medicaid Provider Number:	State License Number:		

5. DIAGNOSIS Client condition which requires requested equipment or services

Primary Diagnosis:	Diagnosis Code (ICD-9):	Date of Onset:
Secondary Diagnosis:	Diagnosis Code (ICD-9):	Date of Onset:
Is Diagnosis a result of an accident?	Yes No	
If yes: Date of accident?	Type of Accident?	Employment Auto Other If Auto: Place (state)?

6. PRIMARY INSURANCE

If the Primary insurance is Medicare or Medicaid, just fill in the ID Number below and proceed to Secondary insurance

Type: Medicare Medicaid/Medical Assistance CHAMPUS Military Coverage Private/Group HMO

Name of Insurance: _____ ID Number: _____

Contact Name: _____ Contact Phone: _____ Contact Fax: _____

Billing Address: _____ State: _____ Zip: _____

Policy Holder / Insured

Name: _____ Phone: _____ Fax: _____

Address: _____ State: _____ Zip: _____

Name of Employer: _____ Employer Address: _____ State: _____ Zip: _____

Policy Number: _____ Group Number _____ Social Security Number: _____

Relationship to Client: _____ Spouse Parent Legal Guardian Other Date of Birth: _____

7. SECONDARY INSURANCE If the Secondary insurance is Medicare or Medicaid, just fill in the ID Number below and proceed to Equipment

Type: Medicare Medicaid/Medical Assistance CHAMPUS/Military Coverage Private/Group H M O

Name of Insurance: _____ ID Number: _____

Contact Name: _____ Contact Phone: _____ Contact Fax: _____

Billing Address: _____ State: _____ Zip: _____

Policy Holder / Insured

Name: _____ Phone: _____ Fax: _____

Address: _____ State: _____ Zip: _____

Name of Employer: _____ Employer Address: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Social Security Number: _____

Relationship to Client: Spouse Parent Legal Guardian Other Date of Birth: _____

7. EQUIPMENT RECOMMENDATION Complete list of all equipment, accessories, and parts requested.

Rental OR Purchase

Qty	Part Number	Description	Price

8. SHIPPING INFORMATION Phone number is required. Medicare funded devices must ship direct to client. **We cannot ship to a Post Office box.**

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____