



Client Information Form

Missing information slows the process. Please make sure that you've provided ALL requested information as well as a copy of the front and back of all insurance cards.

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: () - | Cell Phone: () - | Fax: () - | |
| Email Address: | | | |

2. CONTACT / CLIENT ADVOCATE

The contact person is the person who is assisting the client, or is the emergency contact

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

3. DIAGNOSIS

Client condition that 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | Infectious Disease Present in Home? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, circle type: HIV HBV TB |
| Registered with the Muscular Dystrophy association? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If Yes, office: | Contact name: | PO number: |

4. PRIMARY INSURANCE

| | | | |
|--|--|--------------------------|------------------|
| Type: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare HMO <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid HMO <input type="checkbox"/> Military Coverage <input type="checkbox"/> Private / Group <input type="checkbox"/> HMO | | | |
| Name of Insurance: | Effective Date: | ID Number: | Sequence 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: | <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other | Date of Birth: | |

5. SECONDARY INSURANCE

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

| | | | |
|---|--|--------------------------|------------------|
| Type: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare HMO <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid HMO <input type="checkbox"/> Military <input type="checkbox"/> Private/Group <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other | | | |
| Name of Insurance: | Effective Date: | ID Number: | Sequence 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: | <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other | **Date of Birth: | |

****Must Have Policy Holder/Subscriber Date of Birth to Verify Insurance and Submit Claims Directly****

6. SPEECH LANGUAGE PATHOLOGIST

The SLP is the clinician that performed the evaluation of the client and provided the written report

| | | | |
|---------------------------|------------------------------|------------------|--|
| Evaluation Center: | | | |
| Name: | | | |
| Address: | | E-Mail: | |
| City: | State: | Zip: | |
| Phone: () - | Alternate Phone: () - | Fax: () - | |
| ASHA Number: | State License Number: | | |

7. TREATING PHYSICIAN

The treating physician is the medical doctor who has prescribed the requested equipment

| | | | |
|---------------------------|------------------------|--------------------------------------|--|
| Name: | | NPI#): | |
| Address: | | UPIN (Universal Personal ID Number): | |
| City: | State: | Zip: | |
| Work Phone: () - | Alternate Phone: () - | Fax: () - | |
| Medicaid Provider Number: | | State License Number: | |

8. EQUIPMENT RECOMMENDATION

Complete list of all equipment, accessories, and parts requested.

This need not be completed if equipment is listed in SLP Report or if equipment quote is attached.

Rental **OR** Purchase

| Qty | Part Number | Description | Price |
|-----|-------------|-------------|-------|
| | | | |
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9. SHIPPING INFORMATION

Phone number is required. Medicare funded devices must ship direct to the client. We cannot ship to a Post Office box.

| | | | |
|---------------|--------|------|--------------|
| Name: | | | |
| Organization: | | | |
| Address 1: | | | |
| Address 2: | | | |
| City: | State: | Zip: | Phone: () - |