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: ☐ Married ☐ Single ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Sex: ☐ male ☐ Female Social Security Number:

Currently own a communication device? ☐ Yes ☐ No Make/Model: Date of purchase:

Current place of residence: ☐ Home ☐ Skilled Nursing Facility ☐ Nursing Facility ☐ Custodial Facility (assisted living)
(check all that apply) ☐ Intermediate Care Facility/Mentally Retarded Facility ☐ 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:

Relationship to Client: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other (please specify)

Address: E-Mail:

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:

Address: E-Mail:

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: UPIN (Universal Personal ID Number):

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: ☐ Self ☐ 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 ☐ 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:

8. EQUIPMENT RECOMMENDATION

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

☐ Rental OR ☐ Purchase

Qty	Part Number	Description	Price

9. 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:

Reset all fields