

Client's condition is related to

a. Employment current previous
 Yes No

b. Auto accident Yes No In what state? _____

c. Other accident Yes No

Are you (circle one)

Single

Married

Other

Type of insurance (circle one)

auto work comp medicare group health plan other medical

Insurance company name _____

Insurance plan name or program _____

Insurance company address for claims submission

Claims representative name _____

Claims representative phone _____

Policy Number _____

Claim number _____

Referring Physician Name _____

Address _____

Telephone (_____) _____

Diagnosis number (s) _____

Date of injury / illness _____

If the client has had the same or similar illness in the past give first date:

day month year

Client's relationship to insured

____self ____spouse ____child ____other

Client Status

____Single ____Married ____Other

____Employed ____Part time student ____Full time student

Dates client unable to work in current occupation

From _____
day month year

to _____
day month year

Hospitalization dates related to current condition

From _____
 day month year

to _____
 day month year

If the client is not the primary insured on this policy please complete this section

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Insured's name _____
 Last First Middle

Insured's address

Social security number _____

Date of Birth _____
 day month year

Employers name or school _____

Insurance plan _____

Is there another health benefit plan? _____ Yes _____ No

If yes, complete the following:

Other insured's name _____
Last First Middle

Other insured's policy or group number _____

Other insured's date of birth _____
day month year

Employer's name or school name _____

Insurance plan name or program name _____

CLIENT or authorized person's signature

I authorize the release of any medical or other information necessary to process insurance claims for me. I also request payment of government benefits either to myself or to the party who accepts assignment.

signed

date

printed name

INSURED or authorized person's signature

I authorize payment of medical benefits to the undersigned physician or supplier for services described on claim forms the physician or supplier may submit on my behalf.

signed

date

printed name