FUNDING
Your PRC and Saltillo Funding Source

Client Information Sheet

This required form provides crucial information needed to submit to your funding source.
Please fill out electronically if possible, and complete each section thoroughly.

1. CLIENT: *The client is the person who will be receiving the equipment or services.*

Client Last Name: ______________________ First Name: ______________________

Client Date of Birth: ______________ Sex: Male Female Social Security Number: ______________

Current place of residence *(check all that apply)*: Home Skilled Nursing Facility Nursing Facility Custodial Care Facility Assisted Living Group Home ICFMR Facility Enrolled in Hospice

Address: ______________________ City: ______________ State: ________

Zip: ________ Name of Facility *(if applicable)*: ______________________

Phone Number: ______________ Mobile Phone: ______________

Email Address: ______________________

2. DELIVERY ADDRESS: *Phone number is required. Medicare funded devices must ship direct to client. We cannot ship to a P.O. box.*

Name: ______________________ Facility: ______________________

Address: ______________________ City: ______________

State: ________ Zip: ________ Phone: ______________

3. CLIENT ADVOCATE/EMERGENCY CONTACT: *Please provide emergency contact information (typically spouse, parent, legal guardian, etc.).*

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

Last Name: ______________________ Name: ______________________

Name of Facility *(if applicable)*: ______________________

Address: Same As Above ***or*** ______________________ City: ______________

State: ________ Zip: ________ Email: ______________________

Best Phone: ______________ Alt Phone: ______________

Accept Text Messages? Yes No

Preferred Spoken Language: ______________

4. DIAGNOSIS: *Client's condition deeming the requested equipment or services medically necessary.*

Medical Diagnosis: ______________________

Diagnosis Code *(ICD-10)*: ______________ Date of Onset: ______________

Speech Diagnosis: ______________________

Diagnosis Code *(ICD-10)*: ______________ 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)*? ______________

5. PREVIOUSLY OWNED DEVICE?

No Yes Product Name: ______________________ Delivery/Service Date: ______________

Original Payer: ______________________

6. MEDICARE: *Please attach a legible copy of the front and back of your Medicare card.*

Type: Medicare Medicare Managed Care

Name of Managed Care Organization: ______________________ ID Number: ______________

7. MEDICAID: *Please attach a legible copy of the front and back of your Medicaid card.*

Type: Medicaid Medicaid Managed Care

Name of Managed Care Organization: ______________________ ID Number: ______________

8. PRIVATE INSURANCE: *Please attach a legible copy of the front and back of all insurance cards. Leave section blank if Medicaid only.*

Type: TriCare / Military Insurance Private / Group Insurance

Name of Insurance: ______________________ ID Number: ______________

Group Number: ______________ Phone: ______________ Fax *(if available)*: ______________

**Section 12 on page three for Insurance Policy Holder should also be completed*

9. TREATING PHYSICIAN: *The treating physician is the medical doctor who has prescribed the requested equipment.*

First Name: ______________ Last Name: ______________ Credential (i.e. MD): ________

Name of Facility: ______________________

Address: ______________________ City: ______________ State: ________

Zip: ________ Daytime Phone: ______________

Fax: ______________ NPI Number: ______________ Medicaid Provider Number: ______________

NPI # can be found at: https://npiregistry.cms.hhs.gov *Medicaid submissions only*

10. SPEECH LANGUAGE PATHOLOGIST:

First Name: ______________________ Last Name: ______________________

ASHA Number: ______________________ State License Number: ______________________

Name of Facility: ______________________

Address: ______________________ City: ______________________

State: ______________ Zip: ________ Email: ______________________

Daytime Phone: ______________ Mobile Phone: ______________ Fax: ______________