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FUNDING
Your PRC and Saltillo Funding Source

Post-Trial 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 Not Specificed

2. 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? __________ Accident Type? Work Auto Other

3. 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

4. SPEECH LANGUAGE PATHOLOGIST:

First Name: ______________ Last Name: ______________

ASHA Number: ______________ State License Number: ______________

Name of Facility: ______________________

Address: ______________________ City: ______________

State: __________ Zip: ______ Email: ______________ Daytime Phone: ______________

5. INSURANCE INFO: *Please attach a legible copy of the front and back of all insurance cards.*

Complete all that apply:

Name of Medicaid/Managed Care Organization ______________________ ID # __________

Name of Medicare/Health Care Organization ______________________ ID # __________

Name of Private Insurance ______________ ID #______________ Group #______________