Healthcare Navigation, LLC

Application for Client Services

Demographic Information

Date: _____

Client Name: _____ **Company/Business Name:** _____

Primary Home Address:

_____

_____

Secondary Home Address:

_____

_____

State of Permanent Residence: _____ **E-mail address:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone**: _____

Preferred Method of contact: ___ **Phone** ___**E-mail**

Are you a veteran of the U.S. Military? ____**Yes** ___**No**

Alternate Contact if we are unable to reach you: Name: _____
Phone #_____

Social Security Number: _____ **Date of Birth:** _____

Client Spouse Name: _____

Spouse Social Security Number: _____ **Spouse Date of Birth:** _____

How did you hear about Healthcare Navigation, LLC? Attorney: _____

Accountant: _____ **Financial Advisor:** _____**Other:**_____

Please list the names and relationship of any family members or advisors we are authorized to speak to on your behalf:

_____
_____
_____

Signature of Responsible Party **Date**

If Party responsible for payment is not client, please complete this section:

Guarantor: _____ **Phone number:** _____
Address: _____ **E-mail address:** _____

Insurance Information

Please provide copies of health insurance cards (front and back).

Primary Health Insurance Carrier _____**Policy Holder Name**_____

Policy ID Number**:** _____ Effective Date**:** _____

Group Number**:** _____ Type of Coverage**:** __ Employer __ Individual __ Cobra

Policy Type**:** ____ Indemnity___ HMO___ POS___PPO___

If you have Medicare, complete this section below:

Medicare ID Number**:** _____ Part A: Effective Date**:** _____
Part B: Effective Date _____ Part D**:** Effective Date: _____

Medicare Supplement Carrier Name_____Carrier ID# _____ Effective Date: _____

Part D Prescription Carrier Name_____ Coverage ID # _____Effective Date: _____

Prescription Insurance: _____

Policy ID Number**:** _____ Effective Date: _____

Dental Insurance: _____

Policy ID Number: _____ Effective Date: _____

Long Term Care Insurance: _____

Policy ID Number: _____ Effective Date: _____

If you have previously registered on any of your insurance company's websites, please provide the Following access information:

Plan: _____ **Plan:** _____ **Plan:** _____

User Name: _____ User Name: _____ Username: _____
Password: _____ Password: _____ Password: _____

If you have not previously registered on your insurance company's websites, do you authorize Healthcare Navigation, LLC to register on your behalf? Yes: ____ No: _____

Doctors, Medications and Hospitals

<u>Attention Consultation Clients</u>: The section below is not applicable to the consultation service

Please list any medical conditions for which you seek regular treatment:
_____

_____

Please list any doctors whom you see on a regular basis: **Preferred hospitals:**
_____ _____
_____ _____
_____ _____

Please list your regular medications including dosage and frequency. Please indicate if you take the generic or brand version:

Name	**Dosage**	**Frequency**	**Generic/Brand**	**Mail Order Y/N**

Preferred Pharmacy: _____

Dependent information:

Dependent Name: **_____Full Time Student: ___Yes _____No**

Dependent Social Security Number: _____ Dependent Date of Birth: _____

List any doctors dependent sees on a regular basis: **Preferred hospitals:**
_____ _____
_____ _____
_____ _____

Please list dependent's regular medications including dosage and frequency:

Name	**Dosage**	**Frequency**	**Generic/Brand**	**Mail Order Y/N**

Please list any medical conditions for which you seek regular treatment.

_____
_____

Dependent Name: _____**Full Time Student: ___Yes _____No**

Dependent Social Security Number: _____ Dependent Date of Birth: _____

List any doctors whom you see on a regular basis: **Preferred hospitals:**

_____ _____
_____ _____
_____ _____

Please list your regular medications including dosage and frequency:

Name	**Dosage**	**Frequency**	**Generic/Brand**	**Mail Order Y/N**

Please list any medical conditions for which you seek regular treatment.

_____
_____

Dependent Name: _____**Full Time Student: ___ Yes____ No**

Dependent Social Security Number: _____ Dependent Date of Birth: _____

List any doctors whom you see on a regular basis: **Preferred hospitals:**

_____ _____
_____ _____
_____ _____

Please list your regular medications including dosage and frequency:

Name	**Dosage**	**Frequency**	**Generic/Brand**	**Mail Order Y/N**

Please list any medical conditions for which you seek regular treatment.

_____
_____

Note, if you would prefer you may provide this information over the phone or by email. All information is confidential and is used to evaluate plan options or support you as a liaison between your insurer and providers.