PATIENT INSURANCE FORM

All information is kept strictly confidential

PATIENT'S NAME: ______________________________

Address, City, State & Zip Code: ______________________________

Telephone No.: Home____________________ Cell: ____________________ Other:____________________

Email Address ______________________________

Date of Birth: ______________ Sex M/F:__________ ____________________

***Circle your Primary Insurance Company**: Medicare, BCBS, Aetna, United HealthCare, other__________

Insurance ID Number ______________________________

Policy Holders Name: ______________________________

NAME OF SPOUSE: ______________________________

Address, City, State & Zip Code: ______________________________

Telephone No.: Home ____________________ Work:____________________ Cell: ____________________

Date of Birth: ______________ Sex M/F:__________ Total Family Income: ____________________

Employer:______________________________ Employer Phone No: ____________________

Do You Have Secondary Insurance Coverage? **Yes** ☐ **No** ☐

NAME OF SECONDARY INSURANCE:______________________________

Insurance Policy Number:______________ Group Number______________ Telephone Number:______________

Name of Insured *(if self or spouse so indicate and skip rest of section)*____________________Relationship to Patient __________

Address, City, State & Zip Code: ______________________________

Telephone No.: Home ____________________ Work:____________________ Cell: ____________________

Date of Birth: ____________________ Sex M/F: ____________________

Employer:______________________________ Employer Phone No:____________________

By completing this form I acknowledge that I am requesting to be contacted via telephone by Southern Mobility & Medical (SMM), a Durable Medical Equipment Provider concerning my need for a Power Wheelchair and authorize the use of the information provided herein for this purpose and for the purpose of determining my eligibility. This information is to be kept strictly confidential and used for no other purposes. SMM shall be in compliance with any applicable Hipaa, Federal, State and Local regulations. It is expressly understood that my signature does not create any obligation for me to purchase any equipment.

______________________________ ____________________

Patient's Signature OR Legal Guardian Date

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Print Name of Person Signing and Relationship to Beneficiary