Client Information Sheet - Assignment of Benefits and Patient Release Form

This required form provides crucial information needed to submit to your funding source. Please complete each section thoroughly.

1. Client (The client is the person who will be receiving the equipment or services)

Client Name (Last, First, Mi)

Status: ☐ Married ☐ Single ☐ Other ☐ Employed Social Security: May be needed later - leave blank

Birth Date ☐ Full-Time Student ☐ Part-Time Student

Sex: ☐ Male ☐ Female E-mail Address

Currently own a communication device? ☐ Yes ☐ No Make/Model: Purchase Date:

Current place of residence (check all that apply) ☐ Home ☐ Skilled Nursing Facility ☐ Nursing Facility ☐ Custodial Care Facility ☐ Assisted Living

☐ Group Home ☐ ICFMR Facility ☐ In Hospice Program

Address: Name of Facility

City: State: Zipcode: County:

Best Phone: Fax: Social Security #: May be needed later-Leave blank

Medicare Recipients Only: I certify that I AM NOT receiving in home or facility based hospice care, skilled nursing or hospital based care.
I also understand that if the Medicare Part B claim denies due to enrollment in the above listed types of care. I assume full responsibility for the cost of all equipment provided by Augmentative Communication Consultants, Inc.

Initials

Text

2. Contact/Client Advocate The contact person is the person who is assisting the client or is the emergency contact.

Name: Best time to call AM PM Saturday

Relationship to Client Spouse: Parent: Legal Guardian: Other: Specify:

Address:

City: State: Zipcode: E-Mail Address:

Phone: Alternate Phone: Fax:

3. Speech Language Pathologist - The SLP is the clinician that performed the evaluation of the client and provided the written report.

Name: Name of Facility:

E-Mail: Address:

City: State: Zipcode:

Best Phone: E-Mail: Fax:

ASHA Number: State License Number:

4. Treating Physician

The treating physician is the medical doctor who has prescribed the requested equipment.

Name: | Facility Name:

Address: | City:

State: | Zipcode: | N.P.I. | E-Mail Address:

Work Phone: | Alternate Phone: | Fax:

Medicaid Provider Number: | State License Number:

5. Diagnosis: Client's condition deeming the requested equipment or services medically necessary. MUST INCLUDE DIAGNOSIS CODE

Primary Diagnosis: | Diagnosis Code: ICD-10 | Date of onset:

Secondary 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, What State?

6. Equipment Recommendation Complete list of all equipment, accessories, and parts requested

☐ Rental or ☐ Purchase

Quanity	Part Number(SGD Code)	Description

7. Shipping Information Phone number is required. Medicare funded devices must ship direct to client.

We cannot ship to a Post Office Box. Person must be an adult (over 21 years) to sign for UPS delivery.

Name: | Organization:

Address: | City:

State: | Zipcode: | Phone: | Email:

8. Insurance contact information for Primary Insurance

Type: ☐ Medicare ☐ Medicaid/Medical Assistance ☐ CHAMPUS/ Military Coverage ☐ Private/ Group ☐ HMO

Name of Insurance: | ID Number:

Contact Name: | Contact Phone: | Contact Fax:

Billing Address: | City: | State: | Zipcode:

Policy Holder/Insured **(Please attach legible copy of the front & back of your insurance cards)**

Name: Phone: Fax:

Address: City: State: Zipcode:

Employer name: Employer Address

Employer City: Employer State: Employer Zipcode:

Policy Number: Group Number:

Soc. Security#: May be needed later. Leave blank

Relationship to Client: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other Date of Birth: Email:

9. Insurance contact information for Secondary Insurance:

Type: ☐ Medicare ☐ Medicaid/Medical Assistance ☐ CHAMPUS/ Military Coverage ☐ Private/ Group ☐ HMO

Name of Insurance: ID Number:

Contact Name: Contact Phone: Contact Fax:

Billing Address: City: State: Zipcode:

Policy Holder/Insured **(Please attach legible copy of the front & back of your insurance cards)**

Name: Phone: Fax:

Address: City: State: Zipcode:

Employer name: Employer Address

Employer City: Employer State: Employer Zipcode:

Date of Birth: Policy Number: Group Number:

Relationship to Client: ☐ Spouse ☐ Parent ☐ Other ☐ Legal Guardian

E-Mail Address: Social Security #: May be needed later. Leave blank

If another person is legally responsible for the client, such as parent or co-guardian, list the following information here.

Other party's name: Date of Birth:

Address: City: State: Zipcode:

Social Security # Best Phone: Work Phone:

Other Phone: Fax: E-Mail:

Relationship to Client: ☐ Parent ☐ Legal Guardian ☐ Other

In the military or discharged within the last 90 days? ☐ Yes ☐ No

Current Employer Name:

Address: City: State: Zipcode:

If other Insurance is available Name of Insurance: Policy Number:

Assignment of Benefits Payment Agreement

* I request that payment of authorized health care benefits be made on my behalf to Augmentative Communication Consultants, Inc. (ACCI), P. O. Box 731, Moon Township, PA 15108, for any equipment or services provided to me by ACCI.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services.

* I understand Augmentative Communication Consultants, Inc. (ACCI's) return policy gives me 30 days from the date of shipment to call ACCI to notify us of an items(s) being returned. At that time a return authorization number will be issued and I will have 15 days from the date of the notification to return the items(s) for a refund. The refund will be issued to the paying source. ACCI will use their discretion to accept any returns beyond the initial notification of 30 days. A restocking fee will apply.

* I acknowledge that I have received and understand Augmentative Communication Consultants, Inc. (ACCI's) privacy policy.

* I acknowledge that I have received and understand Augmentative Communication Consultants, Inc. (ACCI's) Patient Bill of Rights.

* I acknowledge that I have been instructed to direct questions, complaints or concerns regarding the performance of my equipment, supplies and/or service to Augmentative Communication Consultants, Inc. (ACCI) at 800 982-2248. I have been advised that ACCI is responsible for resolving my questions or concerns and it is ACCI's goal to respond to questions and concerns within 14 business days of my contact to ACCI.

* I understand that I am responsible for forwarding to Augmentative Communication Consultants, Inc. (ACCI) all "Explanation of Benefits (EOB)" and insurance payments sent to me on the products billed and provided on behalf of the client and/or policyholder, by Augmentative Communication Consultants, Inc. (ACCI), within 10 days of receipt of the EOB and payment.

* I understand that I am financially responsible to Augmentative Communication Consultants, Inc. (ACCI) for any charges not covered by my health care benefits. I agree to notify ACCI of any changes in my Health Care Insurance coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill or balance of the bill as determined by ACCI and/or my health care insurer if the submitted claims, or any part of them, are denied for payment. (ACCI will contact guardian/advocate prior to shipping order.)

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products received. THIS DOES NOT APPLY WHEN MEDICARE DETERMINES THE BALANCE TO BE THE CONTRACTORS OBLIGATION, OR TO MEDICAID RECIPIENTS.

* REQUIRED FOR MEDICARE RECIPIENTS ONLY:

* I acknowledge that I have received and understand the Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) Supplier Standards.

* I confirm that I am not receiving in-home or facility based hospice care, skilled nursing or hospital based care. I understand if the Medicare Part B claim denies due to enrollment in the above listed types of care, I assume full financial responsibility for the equipment provided by ACCI.

* Not all services and/or equipment may be covered or paid for by the Responsible Party's (primary policy holders) private insurance.
The Responsible Party agrees to pay all the deductible, co-pay, non-covered services/equipment, and any portion of covered services not paid in full by private insurance, when applicable. The Responsible Party understands that payments are due immediately upon presentation of the bill. The Responsible Party agrees that ACCI may use any information provided herein for collection purposes.

By signing below, I agree that this Contract shall be governed by the law of the State of PA without regard to the principles of conflicts of law. The venue for any disputes will be exclusively with the appropriate court in PA.

Signature of Responsible Party:

By typing in name, you agree this is official signature

Please print name above:

Mail forms to: Augmentative Communication Consultants, Inc.
Attention: FUNDING
P. O. Box 731,Moon Township, PA 15108
800-982-2248Fax: 412 269-0923
acci1@earthlink.net