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. Clien	t (The client is th	1e person wi	ho will be ree	ceiving the e	quipment	or service	s)			
Client Na	me (Last, First, Mi)									
Status:	🗌 Married	🗌 Single	🗌 Other	🗌 Emp	oloyed	Social Sec	urity: May be n	eeded later - leave blaı	nk	
Birth Date	e			ull-Time udent		art-Time tudent				
Sex:	🗌 Male		Female	E-mail Add	lress					
Currently	own a communica	ition device?	🗌 Yes [No N	1ake/Mode	l:		Purchase D	Date:	
	lace of residence that apply)	🗌 Home	□ Skilled N □ Facility	U	Nursing Facility		ustodial are Facility	□ Assisted Living		
	Group Home		FMR Facility		Hospice ogram					
Address:					Nam	e of Facilit	/			
City:				State:	Zipco	ode:		County:		
Best Phor	ne:	I	Fax:		Soci	ial Security #	: May be neede	d later-Leave blank		
l also unc		Medicare Pa	rt B claim dei	nies due to er	nrollment ir		•	led nursing or hos of care. I assume f		or the cost of all
	Initials				Text					
2. Cont	act/Client Advo	ocate T	he contact p	erson is the	person wh	no is assist	ing the clien	t or is the emerge	ency contact.	
Name:						est time to call	AM	РМ	Saturday	
Relationsl	hip to Client Spo	use:	Parent:	Legal C	Guardian:	Ot	her:	Specify:		
Address:										
City:			S	tate:	Zipcode:	:		E-Mail Address:		

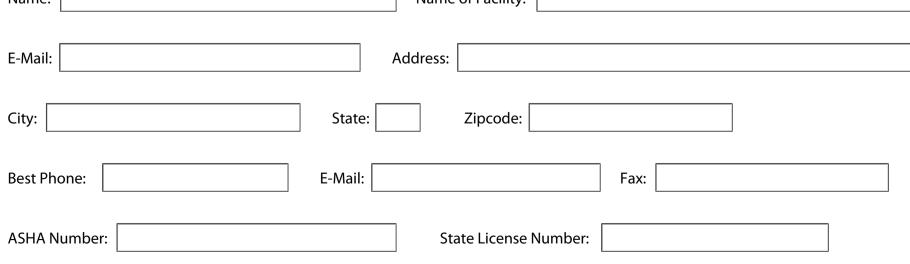
3. Speech Language Pathologist - The SLP is the clinician that performed the evaluation of the client and provided the written report.

Fax:

Name:	Name of Facility:	
Name: 1		

Alternate Phone:

Phone:

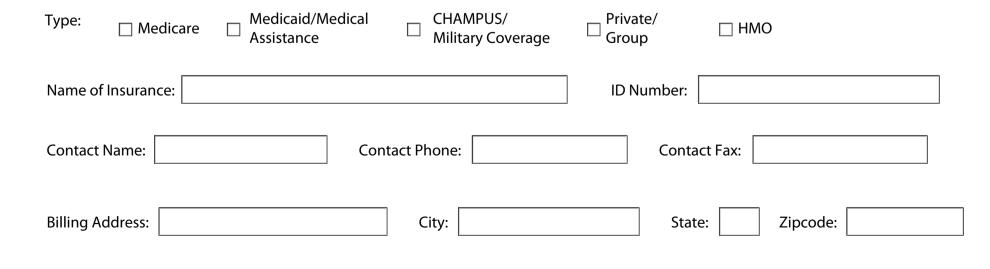


4. Treating Physician The treating physician is the medical doctor who has prescribed the requested equipment.

Name:			Facility Name:		
Address:			Cit	ty:	
State:	Zipcode:	N.P.I.	E-I	Mail Address:	
Work Phone	2:	Alternate Phone:		Fax:	
Medicaid Pr	ovider Number:	State Lice	ense Number:		
5. Diagno	osis: Client's condition deen	ning the requested equipme	ent or services medical	ly necessary. MU	JST INCLUDE DIAGNOSIS CODE
Primary Diag	gnosis:	Diagnosis Code: IC	:D-10	Date of on	set:
Secondary D	Diagnosis:	Diagnosis Code: ICD	-10:	Date of onse	:t:
ls Diagnosis	a result of an accident:	Yes: No:] If YES, Date of Ac	cident:	
Type of Acci	dent? Employment:	Auto:	Other:	lf Auto, Wha	t State?
6. Equipn	nent Recommendation	Complete list of all equipm	nent, accessories, and p	parts requested	
		Rental ^{or} 🗌 Pu	ırchase		
Quanity	Part Number(SGD Code)		Description		
	ng Information Phone nnot ship to a Post Office Bo	number is required. Medic x. Person must be an adult			lient.
Name:			Organization:		
Address:				City:	

State: Zipcode: Phone: Email:

8. Insurance contact information for Primary Insurance



ACCI Toll Free Number 800-982-2248

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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 Guardian Cher Date of Birth: Email:
9. Insurance contact information for Secondary Insurance:
Type: I Medicare Medicaid/Medical CHAMPUS/ Private/ I HMO Assistance Military Coverage Group
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:			Da	ate 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					

800-982-2248

Current Employer Name:							
Address:	City:	State:	Zipcode:				
If other Insurance is available N	lame 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:

* Lacknowledge that Lhave 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

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