Application for Client Services - Individual
Rev. 07/20/2017

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:
____
____

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.

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___

Prescription Insurance: ____________________________________

Policy ID Number**:** _________________ Effective Date: ___________

Dental Insurance: ____

Policy ID Number: _________________ Effective Date: ___________

Long Term Care Insurance: ________________________________

Policy ID Number: _________________ Effective Date: ___________

<u>If you have Medicare, complete this section</u>:

Medicare ID Number**:** _______________________ Part A: Effective Date**:** ___________

Part B: Effective Date _______________________ Part D**:** Effective Date: ___________

Medicare Supplement Carrier Name_______________ID# _____________ Effective Date: _______

Part D Prescription Carrier Name________________ ID # _____________Effective Date: _______

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: _____

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:** _______________

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.

Doctors, Medications, and Hospitals

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

____

____

Please list any doctors whom you see on a regular basis:

Name **Specialty**

____

____

____

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: ______________________________

____

Signature of Responsible Party **Date**

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

Guarantor: __________________________________ **Phone number:** ______________________________

Address: __________________________________ **E-mail address:** ______________________________

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