Healthcare Navigation, LLC

Application for Client Services - Individual
Rev. 05/05/2020

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: _____

If you have Medicare, complete this section:

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: _____

Healthcare Navigation must have access to client insurance company website information for all subscription Clients. If you have not created an on-line account, do you give permission to 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: _____

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.