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**EYEGAZE COMMUNICATION SYSTEM
 User Insurance Information**

The information collected on this form will remain confidential and will be used only for the purpose of providing assistance in obtaining insurance funding for an Eyegaze Communication System.

User Information:

Name: _____	Physician: _____
Address: _____	Physician Phone: _____
Phone: _____	Physician NPI: _____
E-Mail: _____	SLP (if applicable): _____
Date of Birth: _____	SLP Phone (if applicable): _____
E-Mail: _____	SLP NPI: _____
SSN: _____	Diagnosis (w/Code): _____
Is Condition Related to: Employment Auto Accident Other Accident Male Female	Date of Onset: _____
Single Married Divorced	
The user lives in: His/Her family home Nursing home Assisted living facility Is under hospice care	
Buyer Name: _____	Relationship to User: _____

Contact Information for Insurance/Funding Issues:

Name: _____	Office Phone: _____
Company: _____	Home Phone: _____
Address: _____	Cell Phone: _____
_____	Fax: _____
E-Mail: _____	

Method of Payment (Check all that apply):
 Group Insurance Plan Individual Insurance Plan Medicare Medicaid /State: _____ User/Family

Primary Insurance (attach copy of card – front and back):

Name as it appears on card: _____	Member #: _____
Phone # for Provider info: _____	Group #: _____
Claims Address: _____	

Patient Relationship to Insured: Self Spouse Child Other	_____

Secondary Insurance (attach copy of card – front and back):

Name as it appears on card: _____	Member #: _____
Phone # for Provider info: _____	Group #: _____
Claims Address: _____	

Patient Relationship to Insured: Self Spouse Child Other	_____

Please print any information for other/additional insurance on the back of this form.