



Eye Tracking That Brings Power to Sight

EYEGAZE EDGE 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 Edge.

User Information:

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

Contact Information for Insurance/Funding Issues:

Relationship to User: Self Spouse Child Parent Other
 Name: _____ 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.