EYEGAZE INC.

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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 Fax: _____

Phone: _____ SLP: _____

E-Mail: _____ SLP Phone: _____

Date of Birth: _____ SLP Email _____

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.

It is critical to include MD and SLP name and contact information. We cannot file a claim without it.