LC Technologies, Inc.

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 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.

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