Funding Packet

Client information form

Smartbox

Section 1 - Client information

First name _____ Middle name _____

Last name _____ Email _____

Street address _____

City _____ State _____ Zip code _____

Telephone number _____ Date of Birth _____

Marital status ◯ Single ◯ Married

Employment status ◯ Student ◯ Employed ◯ Unemployed

Social Security Number _____ Gender ◯ M ◯ F

Place of residence ◯ Home ◯ Group home ◯ Assisted living

◯ Hospice ◯ Custodial Care Facility ◯ Intermediate Care/MR Facility

◯ Skilled Nursing Facility ◯ Other (specify) _____

Do you own, or have you previously owned a communication device? ◯ Y ◯ N

If yes, device name _____ Date of purchase _____

Section 2 - Diagnosis information

Client medical diagnosis _____

Date of onset _____

Client communication diagnosis _____

Date of onset _____

Is diagnosis result of an accident? ◯ Y ◯ N If yes, date of accident _____

Type of accident _____

Section 3 - Family contact/legal guardian

Name | Telephone number

Alternate phone number

Email address

Relationship to Client

Section 4 - Speech pathologist/evaluator information

First name | Last name

Facility name

Street address

City | State | Zip code

Telephone number | Fax number

Email address

State license number | ASHA number

Section 5 - Treating physician information

First name | Last name

Practice name

Street address

City | State | Zip code

Telephone number | Fax number

Medicaid provider number (if applicable)

NPI number

Section 6 - Insurance information

Note *A copy of the front and back of all insurance cards must be included to prevent processing delays.*

Medicare information (if applicable)

Medicare ID number _____ Is this a Medicare managed care? ◯ Y ◯ N

Medicaid information (if applicable)

Medicaid ID number _____ Is this a Medicaid Managed Care? ◯ Y ◯ N

Name of Managed Care Organization _____

Primary insurance information (if other than Medicare/Medicaid)

Note *A copy of the front and back of all insurance cards must be included to prevent processing delays.*

Insurance company name _____

Employer name _____

Policy holder name _____

Policy number _____ Group number _____

Policy holder date of birth _____

Policy holder address (if different from client)

Street address _____

City _____ State _____ Zip code _____

Policy holder relation to patient _____

Secondary insurance information

Insurance company name _____

Employer name _____

Policy holder name _____

Policy number _____ Group number _____

Policy holder date of birth _____

Policy Holder Address (if different from client)

Street address

City State Zip code

Policy holder relation to patient

Section 7 - Equipment requested

Product name Model number Price

Product name Model number Price

Product name Model number Price

Product name Model number Price

Section 8 - Shipping information

First name Last name

Street address

City State Zip code

Telephone number

Please note: Smartbox cannot ship to a P.O. address.

MEDICARE FUNDED DEVICES MUST BE SHIPPED TO THE CLIENT'S HOME ADDRESS.
Send completed funding package address listed below or fax to 724-304-0678:
Smartbox Assistive Technology
2831 Leechburg Road
New Kensington, PA 15068

Signature(s) of Person(s) completing this form

I verify that all information contained herein is true to the best of my knowledge. I understand that the information provided will be used by Smartbox for the purpose of obtaining funding and hereby give permission to Smartbox to release this information as required by the funding sources listed.

I understand that I may be able to rent or purchase the equipment that has been prescribed by my physician. The rental duration will be according to the manufacturers' policy. I understand that if my insurance coverage requires a capped rental, I will be subject to the Terms and Conditions of the Capped Rental program.

Signature_____ Date_____