



10363 Democracy Lane
 Fairfax, VA 22030
 Phone: 1-703-385-7133
 Fax: 1-703-385-7137

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

Client Representative for Funding Issues (e.g. spouse, SLP, OT, etc.):	
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 (<i>attach copy of card – front and back</i>):	
Name as it appears on card: _____	Member #: _____
Phone # for Provider info: _____	Group #: _____
Claims Address: _____	
Patient Relationship to Insured: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> _____	
Secondary Insurance (<i>attach copy of card – front and back</i>):	

Name as it appears on card: _____	Member #: _____
Phone # for Provider info: _____	Group #: _____
Claims Address: _____	
Patient Relationship to Insured: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> _____	