# Instructions for the Essential Information Form

## General

In order to obtain an Assistive Technology device/service, specific information is required when Medicare, Medicaid, and other medical insurance, is being accessed for reimbursement. Your ability to provide complete and accurate information will insure that the process is not interrupted due to missing information. You will be asked to provide the information about insurance several times over the course of obtaining the assistive technology equipment. This form was designed to allow you to collect the information once and respond to the several requests that will be made by service providers, vendors, and payers over the course of obtaining the AT device/service. Please complete each and every blank on this form, as every piece of information is important!

**Section I:** Please complete this information as it relates to the consumer who is being referred for an AT device/service.

**Section II:** This information identifies a contact person who could answer questions or has access to information about the individual consumer. This section identifies who can act on behalf of the consumer needing the service.

**Section III:** This section requests information about the medical insurance coverage. In many cases an individual may be covered under more than one, or even two, plans. Please provide all information about Medicare, private insurance, and Medicaid in this section even when a plan may not cover AT
devices/services. If an individual has more than 2 types of coverage please attach additional insurance information. Please be sure to identify who the policyholder is (the name of the individual in whose name the policy is issued, their social security number etc). Attach a copy of BOTH sides of each insurance card.

**Section IV:** This section requests information about the consumer's primary care physician. Each physician has a Unique Physician Identification Number (UPIN), a State License number, and many will have a Medicaid Provider number. Very often these numbers are listed on the physician's prescription form. If they are not listed on the prescription form, obtain them from the physician’s office.

**Section V:** You can not procure an AT device/service without a prescription. Depending on the payer's requirements, you may need to obtain multiple prescriptions to cover the evaluation, the device, and/or other services.

**Essential Information Referral Form for AT**

Medicare/Medicaid Purchase & Repairs

**I.** Name _____ Height_____ Weight_____
Address _____
_____

Phone # _____ DOB_____ Social Security # _____

**II.** Contact Person's Name: _____
Relationship to Consumer: _____
Address _____
Phone: Home _____Work _____ Fax _____
Email address _____

**III.** Primary Insurance _____
Policyholder Name _____
Policyholder Address _____
Policyholder Phone _____ Policyholder Date of Birth _____
Policyholder Social Security # _____
Policyholder Relationship to Consumer _____
Secondary Insurance _____
Policyholder Name _____
Policyholder Address _____
Policyholder Phone _____ Policyholder Date of Birth _____
Policyholder Social Security # _____
Policyholder Relationship to Consumer_____

**Copy of Card** (Attach copies of card. Copies of all insurance cards will be required)

**IV.** Referring Physician _____ UPIN # _____
State License # _____
Referring Physician Address

_____
Referring Physician Phone Number

_____
Medicaid Provider #

_____

**V.** Original (not fax) Prescription (specific to request)
Patient Name_____
Diagnosis (specific to what you are requesting)

_____
Service Requested

_____
Date of Onset _____ Prognosis _____
Length of Need

_____
Equipment Needed (list each item - device, mount, switch, etc.) _____
_____

What other equipment is being used in the home by this individual?

_____

Who provided it?

_____

Person Completing Form _____ Date _____
Relationship to consumer_____
Address

_____
Phone Number_____ Fax _____
Email address _____