INSURANCE AND PAYMENT INFORMATION

Do you currently receive home health care visits?   Yes / No

(If you are receiving home health care visits, your insurance may not cover a low vision evaluation.)

Have you had occupational therapy since January 1st of this year?   Yes / No

INSURANCE:

IMPORTANT - As a courtesy to our clients, we verify coverage and benefits before scheduling appointments. To provide you with accurate information about any out of pocket costs you may have, we need your Medicare number, regardless of whether Medicare is your primary insurance or not.

(Check all appropriate boxes)

___Medicare   ___Medicaid   ___Family Care   ___Commercial Insurance   ___Other

1. **Medicare number: Please print clearly on the lines below**

   ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

2. **Supplement or Insurance Policy Name: ______________________________________**

   Provider telephone # (customer service #): ___________________________________

   Policy # or Member #: ____

   Group #: ____