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:

(Check all appropriate boxes)

___Medicare ___Medicaid ___Family Care ___Commercial Insurance ___Other

Medicare number: ____

Supplement or Insurance Policy Name: ____

Insurance provider telephone # (customer service #): ______________________________

Policy # or Member #: ____

Group #: ____