RT RESPIRATORY SERVICES INC.

CLIENT INFORMATION & INSURANCE CHECKLIST

Client Information

Last Name _____ **First Name** _____

Address _____ **City** _____

Province _____ **Postal Code** _____ **Birth Date** _____

Home Phone (_____**)**_____ **Cell Phone (**_____**)**_____

E-mail Address _____

Health Card # _____ - _____ - _____ **Version Code** _____

Family Physician _____ **Referring Sleep Lab** _____

How did you hear about us? _____

Insurance Information Required Calling for Prior Approval

Do you have insurance? ☐ **YES** ☐ **NO** **If YES, please continue to fill out form:**

Insurance Company Name _____

Phone (_____**)**_____

Policy # _____ **Certificate #** _____

Employer Name _____

Is the coverage in your name? ☐ **YES** ☐ **NO** **If NO, please continue to fill out form:**

Insured's Name _____ **Date of Birth** _____

Relationship to Client _____

*** To be filled out by RT Respiratory Office ***

Assignment of Benefits _____ Percentage Covered _____%

Coverage Details _____

_____

Would you like to be contacted for supplies when eligible? ☐ **YES** ☐ **NO**

Date_____ **Client Signature** _____