New Client Information

Name (s):______________________________________ ______________________________________

Address:______________________________________ Name of Child:____________________________

City________________State_______Zip______________ Child 's Date of Birth:_______________________

Home Phone#____________________________________ School District ____________________________

Work/Mobile#____________________________________ Current grade at School :____________________

Email:____ Relationship:______________________________

Diagnoses:____

Does your child have an IEP? Yes/No Eligibility category ________________

Primary Care Physician:

Name:_______________________________ Phone#__________________ Fax#___________________

Address: ______________________________City_____________________State______Zip___________

Insurance Information (also enclose copy of card, front and back)

Insurance:______________________________ Employer:______________________________

Address:_______________________________ Address:_______________________________

_____________________________________ _____________________________________

Phone:________________________________ Phone:_________________________________

ID #__________________________________ HR contact: ___________________________

Group #_______________________________

Insured Party:___________________________

Insured DOB:____________________________

Is this a self-insured Plan?
Yes/No/Not Sure
Very important - please check with corporate HR as soon as possible

Primary Reason for Advocacy Consult

(enclose any relevant documents in addition to health plan documentation, such as Explanation of Benefits, benefit denials, list of specialists you are seeing out of network)

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