|  |  |
| --- | --- |
| IDENTIFYING DATA | Bleeding Disorders Treatment Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eligibility Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Last name:  | First Name: | Email Address: |
| Race:Ethnicity: | Gender: | Birthdate: | Phone Numbers:(H): (W):(C):  |
| Mailing Address: |
| Parents/Guardians: | Phone Number: |
| Emergency Contact: | Phone Number:  |
| Primary Care Provider: |
| ELIGIBILITY INFORMATION | INSURANCE | **Primary (check one)** | **Secondary (check one)** |
| * Private
 | * Medicaid
 | * Medicare/ Medicare Advantage
 | * Private
 | * Medicaid
 | * Medicare/ Medicare Advantage
 |
| * Tricare
 | * Uninsured
 | * Tricare
 | * Uninsured
 |
| Name of Insurance: | Name of Insurance: |
| Does the patient receive SSI or SSDI? Yes No Both:  |
| FAMILY INCOME | **(Only complete this section if uninsured)** |
| SOURCE | RELATIONSHIP TO PATIENT | AMOUNT OF GROSS INCOME |
| MONTHLY | YEARLY |
|  |  |  |  |
|  |  |  |  |
| Family Unit No. of Adults: No. of Children Total: |
| DX | **(To be completed by office staff only)** |
| Primary Diagnosis | * Episodic
* Prophylactic
 | Severity or Type |
| Homecare provider: | Factor Product: |
| PATIENT CERTIFICATION | I hereby certify that the information provided is a true and complete statement according to my best knowledge and belief. If I am receiving medication through the Virginia Bleeding Disorders Program, a full explanation of services and charges has been given to me. I understand that if I give false information, withhold information, or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued. I authorize the release of records necessary to act on the payment of authorized benefits being made in my behalf or to verify the application information. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signature Relationship |