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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | | | | | | | | | | | |