Virginia Bleeding Disorders Program

VDH VIRGINIA DEPARTMENT OF HEALTH

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 ☐ Tricare ☐ Uninsured	☐ Private ☐ Medicaid ☐ Medicare/ Medicare Advantage ☑ 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