

# FORBES REHAB SERVICES, INC.

## Medicaid / Insurance Funding Questionnaire

**Please Note:** The information requested in the red shaded areas must be provided or the funding request can not be processed.

**Return to:** Forbes Rehab Services, Inc.  
49 South Illinois Avenue  
Mansfield, OH 44905  
Attn: Funding Department

### Client Information

The client is the individual for which funding is being pursued.

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

\_\_\_\_\_

County of Residence \_\_\_\_\_

Sex  Male  Female

Non-Verbal  Limited Verbal

Access Method:

Ambulatory  Non-Ambulatory

Touch  Visual Scan  
 Auditory Scan  Other \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_

ICD Code \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_

ICD Code \_\_\_\_\_

Is Diagnosis a result of an accident?  Yes  No

If yes: Date of accident? \_\_\_\_\_ Type of Accident?  Auto  Employment  Other \_\_\_\_\_

Place of residence?  Home  Group Home  Nursing Home  Long Term Care Facility  Other

### Client Contact Information

The client contact is the individual representing the client in a non-professional manner.

Relation to client:  Parent  Guardian  Spouse  Other \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_

C/S/Zip \_\_\_\_\_

Work Phone # \_\_\_\_\_

Email: \_\_\_\_\_

### Client Advocate Information

The client advocate is the individual representing the client in a professional manner.

Relation to client  Speech Pathologist  Case Manager  Other \_\_\_\_\_

Name \_\_\_\_\_

Phone# \_\_\_\_\_

Facility Name \_\_\_\_\_

Alt Phone# \_\_\_\_\_

Address \_\_\_\_\_

Fax# \_\_\_\_\_

C/S/Zip \_\_\_\_\_

Email: \_\_\_\_\_

## Funding Sources / Insurance Coverage Information

Indicate **all** funding sources and insurances that may apply. **Include Clear copy of all ID Cards** (front & back).

MEDICAID /MEDICAL ASSISTANCE

\_\_\_\_\_ **Billing Number** \_\_\_\_\_

Is client part of a Managed Care Program through Medicaid/Medical Assistance?  Yes  No  
If yes, list the information below.

MEDICARE # **STOP** – If Medicare appears on the Medicaid Card, Call for assistance before proceeding as you may have the incorrect Funding Packet!

CHAMPUS/Military (List Information Below)

PRIVATE INSURANCE / HMO / CHAMPUS / MANAGED CARE PROGRAM  
(If YES, List All Information Below)

Insurance Company Name \_\_\_\_\_

Case Manager or Contact (If applicable)

Name \_\_\_\_\_

Phone # \_\_\_\_\_

Fax # \_\_\_\_\_

Name & Address of Policy Holder / Subscriber/ Insured

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Policy Holder Phone # \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Policy or Contract ID# \_\_\_\_\_

Name of Employer \_\_\_\_\_

Group# \_\_\_\_\_

Policy Holder Relationship to Client \_\_\_\_\_

## Referring Physician Information

The referring physician is the medical doctor who has prescribed the requested equipment.

Physician Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Fax # \_\_\_\_\_

C/S/Zip \_\_\_\_\_

Medicaid Provider # \_\_\_\_\_

## Requested Equipment / Recommended Equipment

If Quote was previously obtained, Indicate **Quotation #** \_\_\_\_\_ (or attach copy)  
\*\*\*It will then not be necessary to complete the **Catalog Part #** and **product Description** below.\*\*\*

Please be very specific when listing the requested equipment below. PLEASE feel free to call us toll-free @ 1-888-884-2190 for assistance. If requesting a wheelchair mount, please indicate if the tubing is **round or square/rectangular**.

CATALOG PART # (If available)	PRODUCT DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### Shipping Information

Please provide a complete street address as items cannot be shipped to a Post Office Box.

A phone number with area code is also necessary.

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attention \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

### Mounting Information (If Applicable)

Name & Phone Number of person to be contacted to set up the on-site appointment for the delivery/installation of the mounting system-

\_\_\_\_\_ **Contact Name** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

### A word from Forbes Rehab Services, Inc.

This Funding Questionnaire is used to facilitate the funding process through Forbes Rehab Services, Inc. The information given will be kept confidential. All requested information is necessary for Forbes Rehab Services, Inc. to do its part in this process. Missing information will cause processing delays. To ensure timely processing, please complete the entire Funding Questionnaire. If you have any questions, please contact the Funding Department at Forbes Rehab Services, Inc. at 1-888-884-2190.

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