Claimant Information Form

Claimant Name: _____

Date of Birth: _____/_____/____ **Gender:** _____ **SSN:** _____-_____-_____

Address: _____ **City, State, Zip Code**:_____

Name of Parent/Guardian 1: _____ **Main Phone No.**_____

Email Address: _____

Name of Parent/Guardian 2: _____**Main Phone No.**_____

Email Address: _____

Primary Physician Name: _____

Primary Physician Telephone Number: _____

Primary Physician Fax Number: _____

Claimant Health Insurance Coverage
(Note: Every claimant is required to have primary health insurance coverage per Program requirements. List all other(s) than the Birth Injury Program)

Primary Insurance Carrier: _____ **Telephone Number:** _____

ID#: _____**Group #:** _____ **Effective Date:** _____

Subscriber Name: _____

Other Insurance Carrier: _____ **Telephone Number:** _____

ID#: _____ **Group #:** _____ **Effective Date:** _____

Subscriber Name: _____

Dental Insurance Carrier: _____ **Telephone Number:** _____

ID#: _____ **Group #:** _____ **Effective Date:** _____

Subscriber Name: _____

See reverse side

Claimant Caregiver Information Form

Family Caregiver(s)

Family Caregiver: _____ **Relationship to claimant:** _____

Family Caregiver: _____ **Relationship to claimant:** _____

Family Caregiver: _____ **Relationship to claimant:** _____

Family Caregiver: _____ **Relationship to claimant:** _____

Family Caregiver: _____ **Relationship to claimant:** _____

Family Caregiver: _____ **Relationship to claimant:** _____

Independent Caregiver(s)

Independent Caregiver: _____**Nurse Licenses or certificate: Y or N**

Independent Caregiver: _____**Nurse Licenses or certificate: Y or N**

Independent Caregiver: _____**Nurse Licenses or certificate: Y or N**

Independent Caregiver: _____**Nurse Licenses or certificate: Y or N**

Independent Caregiver: _____**Nurse Licenses or certificate: Y or N**

Independent Caregiver: _____**Nurse Licenses or certificate: Y or N**

Agencies

Agency Name: _____

Agency Telephone Number: _____

Agency Fax Number: _____

Address: _____ **City, State, Zip Code:**_____

Agency Name: _____

Agency Telephone Number: _____
Agency Fax Number: _____

Address: _____ **City, State, Zip Code:**_____
