GAME READY®

Patient Information Sheet

OFFICE USE ONLY:

Delivery Person Name: _____

PATIENT INFORMATION:

Name: Last _____ First _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

E-Mail Address: _____ Date of Birth: ____/_____/_____ (Month/Day/Year) Male ☐ Female ☐
(for Patient identification purposes only)

INSURED'S INFORMATION:

Name: Last _____ First _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Date of Birth: ____/_____/_____ (Month/Day/Year) (for Patient identification purposes only))

PRIMARY INSURANCE:

Insurance Company Name: _____

Identification Number: _____ Employer/Group Number: _____

Claim Number: _____ Phone Number: _____

Claims Mailing Address: _____

Contact Name: _____

☐ Health ☐ Work Comp ☐ Auto ☐ Other: _____

If carrier is Blue Cross, Blue Cross/Blue Shield, Anthem Blue Cross, or an affiliate of Blue Cross, INSURED MUST SEND EXPLANATION OF BENEFITS (EOB)/DENIAL/PAYMENT TO GAME READY to enable Game Ready to bill your secondary insurance.

SECONDARY INSURANCE:

Insurance Company Name: _____

Identification Number: _____ Employer/Group Number: _____

Phone Number: _____ Contact Name: _____

☐ Health ☐ Work Comp ☐ Auto ☐ Other: _____

DIAGNOSIS AND RELATED INFO:

Diagnosis: _____

ICD9: _____

Date of Injury: _____ Date of Surgery: _____

Physician Name: _____ Phone Number: _____

Address: _____

Physician UPIN: _____ Federal Tax ID: _____