Virginia Bleeding Disorders Program

IDENTIFYING DATA

Eligibility Dates:

Program No:	**Last Name:**	**First Name:**	**Email Address:**
Birthdate: / /	**Race Code:**	**S.S. No:**	

Mailing address:

Parents/Guardian:	**Phone No.:** ( ) -
Emergency Contact:	**Phone No.:**

Private Physician/Clinic:	**Physician Address:**	**Phone No.:**

ELIGIBILITY DETERMINATION

PAYMENT SOURCE

Medicaid No.: **Medicaid HMO Name:**	**Medicare No.:**

Primary Ins. Name:	**Policy No:**	**Group No:**

Person Responsible for Payment:

Does the patient receive SSI : Yes ☐ **No:** ☐

FAMILY INCOME

SOURCE	RELATIONSHIP TO PATIENT	AMOUNT OF GROSS INCOME	
		Monthly	**Yearly**
Verification Source:	**Total Income**		

Family Unit:	No. Adults	No. of Children	Total	**Income Level Code:**

Would you like to receive Bleeding Disorders information by email? Yes ☐ No ☐

PATIENT CERTIFICATION

I certify that the information provided is a true and complete statement according to my best knowledge and belief and that 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. In applying for payment by Medicare, Medicaid, Title XX and/or other health care benefits, I authorize release of records necessary to act on this and request that payment of authorized benefits be made in my behalf.
I give my permission for me and/or my dependents to be interviewed, examined and/or treated.

Date **Signature** **(relationship)**

INTERVIEWER: **DATE:**