advocare

Today's Date: _____

Case Registration Form

Patient Information

Patient Last Name: _____First Name: _____MI_____

Date of Birth: _____**Gender:** ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

Address: _____City, State, Zip: _____

Home Phone: (_____) _____

Case Information

Case Manager: _____ Phone Number: _____ Fax Number: _____

Pre Authorization Number: _____

Type of Case: ☐ Motor Vehicle Accident ☐ Worker's Comp ☐ Occupational Health ☐ Other: _____

If auto, state of accident: _____ Date of Injury/Accident: _____ Time of Accident: _____

Employment Related: ☐ Yes ☐ No Cause of Accident: _____

Attorney: _____

COURT INFORMATION

Court Name: _____Court Location: _____

Court Case Name/No. _____ Court Date: _____

Dates Unable to work in current occupation: _____ to _____

Hospitalization dates relation to current services: _____ to _____

Liability Insurance Name: _____ Liability Policy Number: _____

Liability Insurance Address: _____

Adjustor Name: _____ Adjustor Phone Number: _____

Primary Health Insurance Information – *Please provide a copy of ALL Insurance cards, including; motor vehicle insurance ID card and health insurance card*

☐ Self-Pay (no insurance)
☐ Medicaid – ID Number: _____

Patient insured under:
☐ Mother's Insurance ☐ Father's Insurance
☐ OTHER _____

PRIMARY INSURANCE NAME:

Benefit Plan Name_____

Member ID: _____ Group#: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Today's Date: _____

Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

PCP listed on card: _____

SECONDARY INSURANCE NAME:

Benefit Plan Name_____

Member ID: _____ Group#: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

PCP listed on card: _____