
Client Intake Information

Thank you for trusting MediAdvocate. Please complete this form so we can help review your medical insurance claim, billing question, or appeal.

PATIENT INFORMATION

Full Legal Name _____ **Date of Birth** _____ **Phone** _____

Email _____ **Preferred Name** _____ **Best Time to Call** _____

Mailing Address

INSURANCE INFORMATION

Insurance Company _____ **Member ID** _____ **Group Number** _____

Policyholder Name _____ **Relationship to Patient** _____ **Plan Type, if known** _____

Services Requested & HIPAA Authorization

SERVICES REQUESTED

Claims review

Billing support

Appeals assistance

Provider / insurer coordination

Other

Brief Description of Concern

HIPAA AUTHORIZATION

I authorize MediAdvocate and its representatives to use and disclose my protected health information (PHI) for the purpose of assisting with medical insurance claims, billing review, appeals, insurance verification, and coordination with healthcare providers and insurance carriers. This authorization includes access to medical, billing, and insurance records necessary to support my case.

AUTHORIZED REPRESENTATIVE DESIGNATION

I designate MediAdvocate as my authorized representative to act on my behalf in matters related to my health insurance claims and appeals. This includes the right to receive and review claim and benefit information, communicate directly with insurance carriers and providers, submit claims, appeals, and supporting documentation, and assist in resolving insurance-related issues.

Communication & Service Terms

COMMUNICATION AUTHORIZATION

I authorize MediAdvocate to communicate on my behalf with insurance companies, healthcare providers, and related entities. This includes permission to discuss my medical and billing information, submit and receive claims and appeal documentation, communicate by phone, email, fax, and mail, and leave voicemail messages containing limited protected health information when necessary.

Approved communication methods

Phone

Email

Fax

Mail

SERVICE NOTICE

MediAdvocate provides independent patient advocacy services and does not bill insurance companies. All services are billed directly to the client under a separate service agreement or fee arrangement. This form does not assign insurance benefits to MediAdvocate.

EXPIRATION AND REVOCATION

This authorization remains valid for one (1) year from the date of signature unless I revoke it earlier in writing. I understand that I may revoke this authorization at any time by providing written notice to MediAdvocate, except to the extent that action has already been taken in reliance on this authorization.

Acknowledgment & Signature

IMPORTANT ACKNOWLEDGMENTS

I understand that signing this authorization is voluntary.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I understand that MediAdvocate bills clients directly and does not bill my insurance company.

I understand that I should provide accurate and complete information so MediAdvocate can assist me effectively.

SIGNATURE

Patient/Client Name

Date

Patient/Client Signature

If representative, relationship

Personal Representative Name, if applicable

If this form is signed by a personal representative, documentation of authority may be requested by insurers or providers.