



Needs Processing Form
Altrua HealthShare
...caring for one another

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Sections A-D **must** be completed for ALL needs.
 Section E **must** be completed for ALL accidents.

Signature required.

NOTE: Complete all information to avoid delays.

Section A: Head of Household Information MUST BE COMPLETED FOR ALL NEEDS	Section B: Patient Information MUST BE COMPLETED FOR ALL NEEDS
Head of Household's full name: _____ Member ID #: _____ - _____ Date of Birth: ___ / ___ / ___ Daytime Phone #: (_____) _____ - _____ Address: _____ City: _____ State: _____ ZIP: _____	Patient's full name: _____ Social Security #: _____ - _____ - _____ Date of Birth: ___ / ___ / ___ <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p style="text-align: center; margin: 0;">FULL TIME STUDENT/SERVICE VOLUNTEER INFORMATION: <small>Complete if dependent is age 20 or older & attach verification</small></p> <p>School/Charitable/Religious Organization: _____ City/State: _____ Hours: _____</p> </div>

Section C: General Information — MUST BE COMPLETED FOR ALL NEEDS

Detailed description of symptoms & diagnosis/treatment (*if known*) _____

 _____ Date symptoms first noticed ___ / ___ / ___

Has the patient had symptoms before? Yes No *If Yes, give dates* _____

Is this need for maternity? Yes No *If Yes, date of last menstrual period* ___ / ___ / ___

Was patient hospitalized? Yes No Date Admitted ___ / ___ / ___ Date Discharged ___ / ___ / ___

Please list ALL providers, and their addresses, the patient has seen for this need (*use back of form if necessary*) _____

Section D: Insurance Information — MUST BE COMPLETED FOR ALL NEEDS

Does the patient or member have any other resources or coverage that provides any type of benefits for medical expenses? Yes No (if Yes, complete below)

Type of Coverage: Individual Policy Medicare Accident/Cancer/Student Insurance (circle) Group/Group-Type Plan
 Union Health/Welfare Plan or Self-Insured Plan Other: _____

Coverage Information:
 Name of Company: _____ Policy Number: _____
 Name of Insured: _____ Phone Number: (_____) _____ - _____

Section E: Accident Information – COMPLETE FOR ACCIDENTS

Date of Accident ___ / ___ / ___ Time _____ Location of Accident _____

How did the accident happen? _____ Is there any insurance available from other sources? Yes No

Name/Address of Insurance Co. _____ Phone Number (_____) _____ - _____

Name of Policyholder _____ Claim Been Filed? Yes No Adjustor _____

Was this a vehicle-related accident? Yes No **If so, please attach a copy of police report.**

Type of Vehicle _____ Your Auto Insurance Co. _____
 Owner of Vehicle _____ Owner's Auto Insurance Co. _____
 Driver of Vehicle _____ Driver's Auto Insurance Co. _____

Was this a work-related accident or illness? Yes No

Employer's Name _____ Phone Number (_____) _____ - _____

Do you have worker's compensation coverage? Yes No Have you filed a claim? Yes No In Progress

Was this a school-related accident? Yes No

School District _____

Did this occur during school hours? Yes No Did this occur as a result of an extra-curricular school sponsored activity? Yes No

Is there any school insurance available? Yes No

SIGNATURE OF PATIENT OR HEAD OF HOUSEHOLD _____ DATE _____