**SmartCare CLIENT PLAN REQUEST**

**Client Name & ID#:** 123456789

**Program Name:** CRF

Client’s DOB (to verify):

Submitted By:       Date: 10/14/2024

[x]  **New Client Plan** [ ]  **Update Existing Client Plan** (to indicate coverage change or expiration date)

**Check the coverage plan that applies to the client.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Health Plan** | **Insured ID (Policy#, CIN)** | **Effective Date** | Expiration Date |
| Choose an item. |  |  |       |

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Secondary Health Plan | Insured ID (Policy#, CIN) | Effective Date | Expiration Date |
| Choose an item. |       |       |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Tertiary Health Plan | Insured ID (Policy#, CIN) | Effective Date | Expiration Date |
| Choose an item. |       |       |       |

|  |
| --- |
| Assignment/Release of Information obtained? [ ]  Yes [ ]  No |
| Coverage Plan (If ‘Other’ is checked):       |
| Coverage Plan Mailing Address (If known):       |
| **Client’s Relationship to Insured/Subscriber:** | Choose an item. |
| **If Client’s Relationship to Subscriber is not equal to ‘Self’, provide info below, otherwise leave blank.** |
| Subscriber’s Name (Lastname, Firstname)       |
| Subscriber’s Address:       |
| Subscriber’s Sex: | [ ]  Female | [ ] Male | [ ]  Unknown |
| Subscriber’s SSN:       | Subscriber’s DOB:       |