Understanding Benefits. Resolving Bills. Advocating for You.

Client intake form

Complete this form as thoroughly as possible. The information you provide helps us understand your situation and advocate effectively on your behalf. All information is kept confidential.

01 Client information

Full name

Date of birth MM/DD/YYYY

Phone

Email

Mailing address

City

State / ZIP

Preferred contact method

☐ Phone ☐ Email ☐ Text ☐ Mail

02 Insurance information

Insurance company

Plan type

Member ID

Group number

Policyholder name if different from client

Policyholder date of birth
MM/DD/YYYY

03 Provider and claim details

Provider / hospital / facility name

Account or claim number

Date(s) of service

Amount in dispute

04 Describe your concern

Describe the billing issue, claim denial, or benefit question you would like help with. Include any relevant dates, names, or reference numbers.

05 Desired outcome

What outcome are you hoping for? (For example, reduced bill, corrected claim, clearer understanding of benefits, or payment plan.)

06 Additional information

How did you hear about us?

- [ ] Friend / family
- [ ] Healthcare provider
- [ ] Online search
- [ ] Social media
- [ ] Other

Is there anything else we should know before getting started?

07 Client acknowledgment

By signing below, I confirm that the information provided on this form is accurate and complete to the best of my knowledge, and I understand that Coastal Healthcare Advocates will use this information to begin assisting with my case.

Client signature

Date MM/DD/YYYY