



## **Patient Advocate Designation (MI)** **Preparation Form**

This Preparation Form will help you gather your personal information prior to filling out the Questionnaire online so you can quickly and efficiently create your custom document. Please complete all applicable sections as completely as possible. **If any information is not readily available, we recommend you gather this information prior to commencing the online session so you may complete your document.**

If you have any questions as you work on the questionnaire, please contact us at [info@helixcompliance.com](mailto:info@helixcompliance.com).

### **Your General Information**

Your Full Legal Name: \_\_\_\_\_

Your Address: \_\_\_\_\_

State of Residence: \_\_\_\_\_

Zip Code: \_\_\_\_\_

### **Patient Advocate's Information**

Advocate Full Legal Name: \_\_\_\_\_

Advocate Address: \_\_\_\_\_

State of Residence: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### **Alternate Patient Advocate's Information**

Alt. Advocate Full Name: \_\_\_\_\_

Alt. Advocate Address: \_\_\_\_\_

State of Residence: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### **Health Care Questions**

