NYEIS Child Reference #:

Insurance Tool Kit Item 4 **Form B**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

CHILD INSURANCE INFORMATION

Child's Name/Date of Birth: _____ Child's Gender: male ☐ female ☐
Primary Insurance Information:
Insurance Company/Plan Name: _____
Insurance Company Billing address: _____
Policy/Identification (ID) Number: _____
Child's Member ID (if different): _____
Group #: _____
Policy Holder Name: _____ Policy Holder Gender: male ☐ female ☐
Policy Holder Date of Birth: _____
Policy Holder Address: _____
Policy Holder Phone Number: _____
Policy Holder relationship to child: _____

Other Insurance (if applicable):
Insurance Company/Plan Name: _____
Insurance Company Billing address: _____
Policy/ID Number: _____
Child's Member ID (if different): _____
Group #: _____
Policy Holder Name: _____ Policy Holder Gender: male ☐ female ☐
Policy Holder Date of Birth: _____
Policy Holder Address: _____
Policy Holder Phone Number: _____
Policy Holder relationship to child: _____

Medicaid Client Identification Number (CIN) (if applicable): ___ ___ ___ ___ ___ ___ ___ ___ ___
(2 letters, 5 numbers, 1 letter)

_____ _____
Parent/Legal Guardian Signature Date

Parent signature confirms that the insurance information on file is correct.

Insurance Information reviewed at 6 month IFSP:	date_____	no changes ____	parent signature _____
Insurance Information reviewed at 12 month IFSP:	date_____	no changes ____	parent signature _____
Insurance Information reviewed at 18 month IFSP:	date_____	no changes ____	parent signature _____
Insurance Information reviewed at 24 month IFSP:	date_____	no changes ____	parent signature _____
Insurance Information reviewed (other):	date_____	no changes ____	parent signature _____

PARENT ATTESTATION OF NO INSURANCE (if applicable)

Child's Name: _____ Child's Date of Birth: _____

I _____ (please print name) the parent and/or legal guardian of the child whose name is above, attest that as of today's date such child does not have health insurance coverage. I understand that the assigned Early Intervention Program service coordinator must assist me with the identification of and application for health insurance for which such child may be eligible. I also understand that such child is not required to have health insurance in order for Early Intervention Program services to be provided.

_____ _____
Parent/Legal Guardian Signature Date

NEW YORK STATE DEPARTMENT OF HEALTH
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CHILD INSURANCE INFORMATION FORM INSTRUCTIONS

Child's Insurance Information:

In New York State, early intervention services must be provided at no cost to families. However, New York State's system of payments for the Early Intervention Program (EIP) includes the use of public insurance (such as Medicaid and Child Health Plus) and private insurance (such as CDPHP, Empire Plan, and others) for reimbursement of early intervention services. Under New York State Public Health Law (PHL), your service coordinator must collect, and you must provide, information and documentation about your child's insurance coverage, including public and private insurance. This information includes: the type of insurance policy or health benefits plan, the name of the insurer or plan administrator, the policy or plan identification number, the type of coverage in the policy and any other information needed to bill your insurance. Your service coordinator must explain your rights and responsibilities and the protections that the law provides for your family.

Completing this form:

- Your service coordinator can assist you with completing this form.
- Please ensure that the form is filled out completely and accurately.
- If your child has two or more health insurance policies, you must provide information for each policy. (examples below)
    - If your child has two different private insurance policies, you will include information on both policies.
    - If your child has Medicaid and a private insurance, you will include the Medicaid Child Identification Number (CIN) and the private insurance information.
    - If your child has Medicaid Managed Care, both the Medicaid Child Identification Number (CIN) and the Medicaid Managed Care insurance company information will be documented in the insurance information section.
    - If your child has Medicaid Managed Care and a private insurance policy, you will include the Medicaid Child Information Number (CIN), the Medicaid Managed Care insurance company information, and the private insurance policy information.
- Your service coordinator must review this insurance information at each Individualized Family Service Plan (IFSP) meeting/review. You must sign this form at each IFSP meeting/review to confirm that your insurance has not changed. If your insurance changes, you will need to complete a new form.
- Please inform your service coordinator if your child's insurance coverage changes at any time.

Parent Attestation of No Insurance (if applicable):

- You must complete and sign this attestation if your child does not have health insurance coverage.
- A new attestation must be signed at each IFSP meeting/review (unless your child has obtained insurance coverage).
- If your child does not have insurance, EIP services will still be provided at no cost to you.
- Your child is not required to have health insurance to receive EIP services, however your service coordinator must assist you with identifying and applying for health insurance that your child may be eligible for.

Please contact your service coordinator if you have any questions while completing this form.