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

NYEIS Child
Reference #:

Insurance
Tool Kit Item 5
Form C

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

AUTHORIZATION TO RELEASE HEALTH INSURANCE INFORMATION

Pursuant to Section 2559(3)(d) of NYS Public Health Law and
Section 3235-a(c) of the Insurance Law

Insured's (Child's) Name:	Date of Birth:
Parent/Legal Guardian's Name:	Date of Birth:
Insurance Company Name:	Insurance Plan Name/Type:
Insurance Company Address:	Insurance Company Phone No:
Policy Holder's Name and Address:	Policy/ID No.: Child's Member ID No.: Group No. (if applicable):
Service Coordinator Name:	Service Coordinator Agency: Nassau County Department of Health
Service Coordinator Address: 60 Charles Lindbergh Blvd, Uniondale, NY 11553-3683	Service Coordinator Phone No.: (516) 227-
Municipality: Nassau County	Date Sent to Insurer:

I request and authorize the release of health insurance coverage information for the insured named above to my child's and family's early intervention service coordinator, provider(s), the municipality which administers the local Early Intervention Program, and the NYS Department of Health and/or its early intervention fiscal agent.

I authorize the exchange of information between these parties and the insurer named above for the purposes of facilitating claiming and assisting in the adjudication of claims for services rendered under the Early Intervention Program:

I further consent and authorize providers who submit claims to the above referenced insurer to provide such information as may be required by the insurer to facilitate claiming and payment for services rendered under the Early Intervention Program.

This request applies only to health insurance coverage under the insured's policy, plan or benefit package for the purposes of facilitating payment from the insurer for services rendered under the Early Intervention Program.

Parent/Guardian's Signature: _____

Date Signed: _____