NYC EARLY INTERVENTION PROGRAM
INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY INFORMATION

Company Name: _____ Type of Plan: _____
(For Child Health Plus, write insurance company name.)

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Policyholder's Name (Last, First): _____

Date of Birth: _____/_____/_____ Policyholder Relationship to Child: _____

Policyholder's Address: _____Phone: (_____) _____

City: _____ State: _____ Zip: _____ Effective Date: From _____ To _____

Policy #: _____ Group Number: _____

Self-Employed (Y/N): ____ Employer's Name *(if policy through employer)*: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

D. <u>MEDICAID INFORMATION</u> (Attach a copy of child's Medicaid card)

Child covered by Medicaid? □ Yes □ No

Child's Medicaid/CIN #: _____/_____/_____/_____/_____/_____/_____/____
Letter Letter Number Number Number Number Number Letter

E. <u>ACKNOWLEDGEMENT OF NEW YORK CITY EI PROGRAM INTENT TO EXERCISE SUBROGATION RIGHTS</u>

I attest that the information I have provided in this acknowledgment is accurate and true to the best of my knowledge. I understand that the New York City Early Intervention Program intends to seek payment from third party payors. I give the New York City Early Intervention Program permission to seek reimbursement from my health insurance company. I authorize the release of any medical information or other information necessary to process claims. I authorize payment of medical benefits to the New York City, Early Intervention Program. I have been informed that under the Public Health Law and Insurance Law the use of insurance is at no cost to me.

_____ _____
Policyholder Signature *Date*

FOR EIP OFFICE USE ONLY *EIP Data Entry:* _____ *Date:*_____