# NYC EARLY INTERVENTION PROGRAM
# INSURANCE INFORMATION INSTRUCTIONS

Service Coordinators (SC) must use this form to record the child's insurance information prior to the initial IFSP meeting, and whenever the family informs the SC that the child's insurance coverage has changed.

For the purpose of this requirement "insurance" refers to any third-party coverage, including private insurance, Medicaid, Medicaid managed care, and Child Health Plus.

1. Complete all of Sections A and B.
2. If the child has insurance, complete all areas of either Section C or D as directed below.
3. Fax the completed form to the NYC Early Intervention Program (EIP) Regional Office ***and*** bring a copy to the IFSP meeting.
4. If the parent refuses to provide the information, follow the instructions regarding parent refusal and complete the **Parent Refusal to Provide Insurance Information Form.**

Families must be informed that according to State regulations, (NYCRR Sec 69-4.22) "*the municipality shall pay all co-payments and deductibles to meet any requirement of an insurance policy or health benefit plan in accessing funds applied to payment for early intervention services*."

## A. IDENTIFYING INFORMATION

**Child's Name** (Last, First and Middle)**:** The child's complete legal name (no nicknames), last name, followed by first and middle names. Verify correct spelling.

**EI #:** The identification number assigned by the NYC EIP to this child.

**DOB:** Date of child's birth, in month, day and year order.

**Date Information Collected:** The date of the meeting with the parents when this information was obtained.

**Service Coordinator & SC #:** The Initial Service Coordinator's name and SC number.

**SC Provider Agency & Agency EI #:** The employing service coordination agency name and Early Intervention (EI) contract number.

**No Insurance:** If the child has no insurance, check the box marked "No Insurance" **and** indicate, by checking the appropriate box, whether the application process has begun for Medicaid, Child Health Plus or Social Security Income (SSI).

## B. HEALTH CARE PROVIDER

**Child's Primary Care Provider:** The name of the physician (or in some cases the clinic) who provides primary health care to the child. Include the phone number and address for the primary care provider.

## C. INSURANCE INFORMATION

**More than one insurance plan:** If the family is covered by more than one plan, ask the parent to provide complete information about all third party payers

# NYC EARLY INTERVENTION PROGRAM
# INSURANCE INFORMATION INSTRUCTIONS

## PRIMARY AND SECONDARY INSURANCE COMPANY INFORMATION

**Company Name:** The complete and correct name of the insurance company (verify name and spelling). If the family is covered by Child Health Plus, record the insurance company name; *do not write "Child Health Plus."*

**Type of Plan:** This information may be available from the family, the documentation of the family's plan, or from the insurance company. Examples of the general types are below.

- **Health Maintenance Organizations (HMO)**
- **Point of Service Plans (POS)**
- **Preferred Provider Organizations (PPO)**
- **Fee for Service (FFS) – Indicate Basic, Major or Comprehensive**

**Address, City, State, and Zip & Phone:** The insurance company's complete billing address and phone number (important for obtaining authorizations).

**Subject to New York State Insurance Law (if known):** Indicate if the insurance company is subject to NYS insurance law, or if this is not known.

**Policyholder's Name:** The legal name, last name first, followed by first and middle names of the person who holds the insurance policy. Verify correct spelling.

**Date of Birth:** Policyholder's date of birth, in month, day and (four digit) year order.

**Policyholder Relationship to Child:** The relationship of the policyholder to the child, e.g., mother, father, step-parent, legal guardian, etc.

**Policyholder's Address, Apt. #, City, State, and Zip & Phone:** The complete address where the policyholder is currently residing and the home telephone number.

**Effective Dates From:** The date on which the plan became effective. <u>This information is mandatory</u>. If the policyholder does not know exactly when the plan began, it is acceptable to use the date when the information is collected.

**Effective Dates To:** The expected date on which the insurance will change. If there is no change expected, leave the space blank.

**Policy #:** The number of the insurance policy. This number can be obtained from the family or frequently from the insurance card. Other names for policy number might be Member ID, Participant Number, etc.

**Group Number:** The number of the "group". This number can be obtained from the family or frequently from the insurance card. Other names used may be Plan Number, Plan ID, etc.

**Self-Employed:** Is the policyholder self-employed? Write Y (yes) or N (no).

**Employer's Name *(if policy through employer)*:** The complete legal company name including abbreviations such as LLC, Inc., etc.

**Employer's Address, Apt. #, City, State, and Zip & Phone:** The employer's complete address and telephone number.

# NYC EARLY INTERVENTION PROGRAM
# INSURANCE INFORMATION INSTRUCTIONS

## 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 |

**Note: All Medicaid assigned Client Identification Numbers follow this format.**

Verify against the child's Medicaid card/documentation that the number is correct. You must attach a copy of the child's Medicaid card.

## E. <u>ACKNOWLEDGEMENT OF NYC EI PROGRAM INTENT TO EXERCISE SUBROGATION RIGHTS</u>

Obtain signature of the policyholder and date of signature.