Insurance
Tool Kit Item 3
Form A

NYEIS Child
Reference #:

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

COLLECTION OF INSURANCE INFORMATION

DATE INSURANCE INFORMATION COLLECTED/UPDATED: mm/dd/	*Is the Insurance Plan Regulated by New York State? Yes ☐ No ☐ If no, has the parent consented to use of their insurance benefits? Yes ☐ No ☐	Is the Insurance Plan: Primary ☐ or Secondary ☐
Child's Name:	Child's Date of Birth: mm/dd/	Child's Gender:
Parent/Guardian Name:	Parent/Guardian Date of Birth: mm/dd/	Parent/Guardian Phone No.:
Insurance Company Name:	Insurance Company Phone No:	Insurance Company Billing Addre
	Insurance Plan/Policy Name:	Type of Insurance Plan:
Policy Holder Name:	Policy Holder Date of Birth: mm/dd/	Policy Holder Gender:
Policy Holder Address:	Policy Holder Phone Number:	Policy Holder Relationship to Child:
Policy Holder Employer Name:	Employer Address:	Employer Phone No.:
Policy No. for Billing:	Child's Member Identification No:	Group Number (if applicable):
	Policy Effective From Date: mm/dd/	Policy Effective To Date: mm/dd/
Is the Plan Child Health Plus? Yes ☐ No ☐	Is the Plan Medicaid Managed Care? Yes ☐ No ☐	Is the Plan a self-funded plan? Yes ☐ No ☐
***Medicaid CIN Number (2 alpha, 5 numeric, 1 alpha):	CIN Effective From Date: mm/dd/	CIN Effective To Date: mm/dd/
Service Coordinator Name:	Service Coordinator Phone No:	Service Coordinator Fax No.:
Municipality Name:	Service Coordinator Agency:	Service Coordinator Address:

Insurance Information reviewed at 6 month IFSP: date_____ initials _____ no changes _____ new form _____
Insurance Information reviewed at 12 month IFSP: date_____ initials _____ no changes _____ new form _____
Insurance Information reviewed at 18 month IFSP: date_____ initials _____ no changes _____ new form _____
Insurance Information reviewed at 24 month IFSP: date_____ initials _____ no changes _____ new form _____
Insurance Information reviewed: date_____ initials _____ no changes _____ new form _____
mm/dd/

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)

_____ mm/dd/yyyy _____
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: mm/dd/
Parent/Legal Guardian's Name:	Date of Birth: mm/dd/
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:
Service Coordinator Address:	Service Coordinator Phone No.:
Municipality:	Date Sent to Insurer: mm/dd/

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: _____

NYEIS Child Reference #:

Insurance Tool Kit Item 6 **Form D**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

REQUEST FOR COVERAGE INFORMATION
Pursuant to Section 3235-a(c) of New York State Insurance Law

Child's Name (First/MI/Last):	Child's Date of Birth: mm/dd/
Municipality:	Date Sent to Insurer: mm/dd/
Name of Parent/Legal Guardian:	Phone No.:
Insurance Company/Plan Name:	Insurance Company Address:
Policy Holder Name and Address:	Policy Holder Relationship to Child:
Policy Holder Date of Birth: mm/dd/	Policy No. for Billing:
Policy Holder Employer Name:	Policy Holder Employer Address:
Child's Member Identification No.:	Group No. (if applicable):
Early Intervention Service Coordinator:	Service Coordination Agency:
Service Coordinator Phone No.:	Service Coordinator Fax No.:
Service Coordinator Address:	

Dear Insurer:

This form requests information about the above named child's insurance coverage. The parent/guardian of the above named child has authorized release of this information (authorization form enclosed). As per requirements in Section 3235-a(c) of the New York State Insurance Law, we request that you complete and return this form to the Early Intervention Program at the address provided above. Section 3235-a(c) of the State Insurance Law requires this information to be returned within 15 days of request. Provision of this information will assist both the authorized providers and the insurer in claims processing.

Please provide the following requested information regarding the above named child's benefits as the insured.

Is the child's health coverage:

a) A health insurance policy, plan or benefit package regulated under New York State Law — Yes☐ No☐
b) Child Health Plus — Yes☐ No☐
c) Other government plan (e.g., Medicaid Managed Care) — Yes☐ No☐
d) A self-insured plan governed by ERISA or other plan not subject to regulation under New York State Insurance Law? — Yes☐ No☐

Please indicate the effective dates of coverage for this policy: _____

Revised May 2017

NYEIS Child
Reference #:

Child's Name (First/MI/Last):	Child's Date of Birth: mm/dd/

Visit Limit Information

If the child's insurance policy, plan or benefit package **IS** a policy regulated by New York State Insurance Law and **IS NOT** Medicaid, Champus, or a self-insured plan or other plan not subject to New York State Insurance Law, please indicate the number of annual visits available for the covered services identified below (if no coverage is available, please indicate by placing a 'N' in the second column and a '0' in the third column).

Service	Covered (Y/N)	Number of Annual Visits
Applied Behavior Analysis		
Assistive Technology/Durable Medical Equipment		
Audiology Services		
Nursing Services		
Diagnostic and Evaluation Services		
Nutrition Services		
Occupational Therapy		
Physical Therapy		
Psychological Services		
Social Work Services		
Special Instruction		
Speech Language Therapy		
Vision Services		

Is prior authorization for covered services required? **Yes**☐ **No**☐

Are there specific referral procedures that must be followed? **Yes**☐ **No**☐

If yes, please describe the procedures that must be followed:

_____

_____

Please provide the name, telephone number, and email address of an appropriate contact person for questions about the information on this form:

_____ _____ _____

Name Phone E-mail

Please return completed form to the Early Intervention Service Coordinator at the address on the first page of this form. Thank you for your assistance.

Revised May 2017