Insurance
Tool Kit Item 3
Form A

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

NYEIS Child
Reference #:

COLLECTION OF INSURANCE INFORMATION

DATE INSURANCE INFORMATION COLLECTED/UPDATED:	*Is the Insurance Plan Regulated by New York State? Yes No	Is the Insurance Plan: Primary or Secondary
Child's Name:	Child's Date of Birth:	Child's Gender:
Parent/Guardian Name:	Parent/Guardian Date of Birth:	Parent/Guardian Phone No.:
Insurance Company Name:	Insurance Company Phone No:	**Insurance Company Billing and Claiming Address:
	Insurance Plan/Policy Name:	Type of Insurance Plan:
Policy Holder Name:	Policy Holder Date of Birth:	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:	Policy Effective To Date:
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:	CIN Effective To Date:
Service Coordinator Name:	Service Coordinator Phone No:	Service Coordinator Fax No.:
Municipality Name:	Service Coordinator Agency:	Service Coordinator Address:

Insurance information must be reviewed at least quarterly and at any time the child's insurance status changes.:

Insurance Information reviewed: date_____ initials _____ no changes new form
Insurance Information reviewed: date_____ initials _____ no changes new form
Insurance Information reviewed: date_____ initials _____ no changes new form
Insurance Information reviewed: date_____ initials _____ no changes new form
Insurance Information reviewed: date_____ initials _____ no changes new form

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

COLLECTION OF INSURANCE INFORMATION FORM A INSTRUCTIONS

Medicaid and Private Insurance:

If the family has both private insurance and public insurance (Medicaid) coverage, claims for payment of early intervention services will first be billed to private insurance and only the remaining balance will be billed to public insurance (Medicaid) for payment. The child's insurance plan will be billed for early intervention services and no additional consent is needed from the family if the child's insurance is subject to New York State Insurance Law.

Note: Asterisks below correspond to boxes on Form A.

*For assistance in determining whether an insurance plan is regulated in New York State, please contact the insurer directly.

**The insurance company must be contacted to confirm the billing and claiming address. Once confirmed, this should be entered/verified in NYEIS.

***If the family has a Medicaid card and CIN#, the CIN# must be entered in NYEIS. If the Medicaid coverage is a Medicaid managed care plan, the managed care insurer/insurance information must also be entered on the commercial insurance page and marked "Yes" for Medicaid Managed Care after entering the Medicaid coverage. Please see Item 12 in this tool kit for more information.

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 : date_____ no changes ____ parent signature _____
Insurance Information reviewed : date_____ no changes ____ parent signature _____
Insurance Information reviewed : date_____ no changes ____ parent signature _____
Insurance Information reviewed : date_____ no changes ____ parent signature _____
Insurance Information reviewed : 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
BUREAU OF EARLY INTERVENTION

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 your child's insurance information with you at least quarterly. If your insurance changes, you will need to complete a new form.
- Please inform your service coordinator immediately if your child's insurance coverage changes.

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 Individualized Family Service Plan (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.

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:
Service Coordinator Address:	Service Coordinator Phone No.:
Municipality:	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: _____

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:
Municipality:	Date Sent to Insurer:
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:	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 October 2019

NYEIS Child Reference #:

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

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, Child Health Plus, 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 October 2019

NYEIS Child Reference #:

Insurance Tool Kit Item 8 **Form E**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

WRITTEN REFERRAL FROM PRIMARY HEALTH CARE PRACTITIONER
DOCUMENTATION OF MEDICAL NECESSITY FOR THIRD-PARTY CLAIMING
Pursuant to Section 2559(3)(a)(ii) of New York State Public Health Law

Child's Name (First/MI/Last):	Child's Date of Birth:
Name of Parent/Legal Guardian:	Phone No.:
Service Coordinator:	Phone No.

Dear Primary Care Practitioner:

Pursuant to New York State Public Health Law Section 2559(3)(a)(ii), parents are required to provide the Early Intervention Program with a written referral from a primary health care practitioner as documentation of the medical necessity of early intervention services for their children who have been found eligible through a multidisciplinary evaluation for the Early Intervention Program. This information is sought in order to facilitate claims and payment processing for these services from third-party insurance. The New York State, Bureau of Early Intervention developed this form to facilitate a complete and accurate referral. However, you may use the form of your choosing provided it contains all the required information. Thank you for your support in providing the information requested below.

Patient Assessment and Relevant Medical History

Diagnosis, including diagnosed condition or developmental delay (and accompanying ICD code), relating to the need for Early Intervention Program services

Early Intervention Program Services identified in the child's Individualized Family Service Plan (IFSP)

Service Type	Frequency/Duration	Prior Auth No. *(insurer use only)*
	Per the IFSP	
	Per the IFSP	
	Per the IFSP	

Service Type	Frequency/Duration	Prior Auth No. *(insurer use only)*
	Per the IFSP	
	Per the IFSP	
	Per the IFSP	

I understand that the Early Intervention Program services listed above may require ongoing evaluation/assessment to be conducted on a regular basis by a qualified professional to evaluate the progress of the child.
I refer _____(*child*) to the Early Intervention Program to obtain the services identified in his/her IFSP.

Practitioner Signature: _____(*original*) Date: _____

Practitioner Name (Print): _____ Phone No.: _____

Practitioner Address: _____

New York State License No.: _____ NPI No.: _____