NYC EARLY INTERVENTION PROGRAM
INSURANCE INFORMATION

Complete this form in its entirety and fax the form and a copy of the insurance card(s) to the Early Intervention Regional Office in the child's borough of residence. Use the following fax numbers:

Bronx (718) 410-4482 Brooklyn (718) 722-2310 Manhattan (212) 487-3930
Queens (718) 271-6114 Staten Island (718) 420-5360

Note: If a copy of the insurance card(s) cannot be obtained at the initial meeting with the parent/caregiver, the parent/caregiver should make a copy available no later than the Initial IFSP meeting.

( ) *Check if this form contains information different from the initial insurance information form.*

Please Print

A. IDENTIFYING INFORMATION

CHILD'S NAME (Last, First and Middle): _____

EI #: _____ DOB: ____/____/____ Date Information Collected: ____/____/____

Service Coordinator: _____ SC #: _____

SC Provider Agency: _____ Agency EI #: _____

☐ No insurance Applications in process: ☐ Medicaid ☐ Child Health Plus ☐ SSI

B. HEALTH CARE PROVIDER

Child's Primary Care Provider: _____ Phone: (____) _____

Address: _____

C. INSURANCE INFORMATION *Attach a Copy of the Insurance Card(s).*

PRIMARY INSURANCE COMPANY INFORMATION

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

Address: _____

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

Subject to New York State Insurance Law (if known): _____Y _____ N _____ Unknown

Flexible Spending Account: [ ]

Policyholder's Name (Last, First, and Middle) _____

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: (____) _____

Continued on Page 2

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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:*_____