NYEIS Child Reference #

_____

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

CHILD INSURANCE INFORMATION

Insurance
Tool Kit Item 4
Form B

Child's Name: _____ **Child's Date of Birth:** _____

Primary Insurance Information: Child's Gender: male _____ female _____

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/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: _____

Medicaid Client Information 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 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