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/yyyy	*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/yyyy	Child's Gender:
Parent/Guardian Name:	Parent/Guardian Date of Birth: mm/dd/yyyy	Parent/Guardian Phone No.:
Insurance Company Name:	Insurance Company Phone No:	Insurance Company Billing Address:
	Insurance Plan/Policy Name:	Type of Insurance Plan:
Policy Holder Name:	Policy Holder Date of Birth: mm/dd/yyyy	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/yyyy	Policy Effective To Date: mm/dd/yyyy
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/yyyy	CIN Effective To Date: mm/dd/yyyy
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/yyyy

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

COLLECTION OF INSURANCE INFORMATION (continued)

*For assistance in determining whether a particular insurance plan is regulated in New York State, please contact the insurer directly and/or use the additional guidance provided in the tool kit in items #15 and #16.

**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 #13 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

Notice of Parent Declination to Provide Insurance Information to the Early Intervention Program

I, _____(*service coordinator*), am notifying the State Department of Health that _____(*parent*) has declined to provide health insurance information to the Early Intervention Program and has not provided documentation that the insurance policy under which their child, _____(*child*), is covered is not regulated by New York State Insurance Law and regulations.

The parent declined for the following reason(s):

Parent Address and Phone Number:

Service Coordinator and Agency (if applicable), Address and Phone Number:

I certify that the following actions were taken in an effort to obtain insurance information from the parent:

- The service coordinator requested the information of the parent.

  Yes ☐ No ☐
- The service coordinator reviewed the protections in Public Health Law and Insurance Law that assure use of insurance is at no cost to the parent.

  Yes ☐ No ☐
- The parent was asked and could not or did not provide documentation from their insurer that insurance coverage applicable to their child is not governed under New York State laws and regulations.

  Yes ☐ No ☐
- The parent has been informed and understands that this notice is maintained in the child record and is sent by the service coordinator to the New York State Department of Health, Bureau of Early Intervention.

  Yes ☐ No ☐

_____ _____

Initial/Ongoing Service Coordinator Date

Revised 2/14

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/yyyy
Parent/Legal Guardian's Name:	Date of Birth: mm/dd/yyyy
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/yyyy

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/yyyy
Municipality:	Date Sent to Insurer: mm/dd/yyyy
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/yyyy	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: _____

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NYEIS Child Reference#:

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

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.

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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: mm/dd/yyyy
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.: _____

NYEIS Child Reference#:

Insurance Tool Kit Item 11 **Form F**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

CONSENT TO BILL NON-REGULATED INSURANCE

TODAY'S DATE: mm/dd/yyyy	*Is the Insurance Plan Regulated by New York State: Yes ☐ No ☐
Child's Name:	Child's Date of Birth: mm/dd/yyyy
Insurance Company Name:	Insurance Plan Name/Type:
Insurance Company Address:	Insurance Company Phone No:
Policy Holder's Name:	Policy Holder's Relationship to Child:
Policy Holder's Address:	Policy/ID No.: Child's Member ID No.: Group No. (if applicable):
Name of Service Coordinator:	Service Coordinator's Phone Number:
Consent Effective From Date: mm/dd/yyyy	Consent Effective To Date: mm/dd/yyyy

Please Read

I understand that I can decide if I wish to give my permission for my health insurance plan, which is <u>not</u> regulated by New York State Insurance Law, to be billed to help pay for the Early Intervention Program services my child and family receive.

I understand that my consent is voluntary, that I can revoke my consent at any time, and that the revocation of consent will not be retroactive.

I understand that if I give this permission, my insurance benefits may not be protected by State Insurance or Public Health Law and that my insurer <u>may not</u> be prohibited from:

- Applying the early intervention services to the policy's lifetime or annual monetary or visit limits.
- Discontinuing or not renewing my insurance coverage because my child receives early intervention services.
- Increasing my insurance premiums because my child is receiving early intervention services.

Consent to Bill Non-Regulated Insurance

☐ **I give my consent** to my Early Intervention Program providers to access benefits through my health insurance plan, which is NOT regulated by New York State Insurance Law, to help pay for the early intervention services my child and family receive.

☐ **I do NOT give my consent** to my Early Intervention Program providers to access benefits through my health insurance plan, which is NOT regulated by New York State Insurance Law, to help pay for the early intervention services my child and family receive.

Parent Name Parent Signature Date

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