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

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.

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):  Y  Employer’s Name (if policy through employer):  

Employer’s Address:  
City:  State:  Zip:  Phone: ( )  

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INSURANCE INFORMATION

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. MEDICAID INFORMATION (Attach a copy of child’s Medicaid card)

Child covered by Medicaid? □ Yes □ No

Child’s Medicaid/CIN #: __________________________

Letter Letter Number Number Number Number

E. ACKNOWLEDGEMENT OF NEW YORK CITY EI PROGRAM INTENT TO EXERCISE SUBROGATION RIGHTS

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: ________________
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