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: (_____ ) ___________________________

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