|  |  |
| --- | --- |
| *North Carolina Infant-Toddler Program* |  |

*Insurance Information Worksheet*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***The service provider is responsible for verification of insurance information. The information on this form is not a guarantee of payment.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Child Information:** | | | | | | | | | |  | |  | | | | | | | | *ITP SFS %* | | | | | *Monthly*  *Maximum Cap* | | | | *Date Completed* | |
|  | | | | | | | | | |  | |  | | | | | | | |  | | | | |  | | | |  | |
| *Child’s First Name* | | | | | | | | | | *Middle/Suffix* | | | *Child’s Last Name* | | | | | | |  | | | | |  | | | |  | |
|  | | | | | | | | | |  | | | | |  | | |  | |  | | | | |  | | | |  | |
| *Address* | | | | | | | | | | *City* | | | | | *State* | | | *Zip Code* | |  | | | | | | | | | | |
|  | | | | | | *Sex:* Male  Female | | | | | | | | |  | | | | | | | | | |  | | | | | |
| *Date of Birth:* | | | | | |  | | | | | | | | | *Home Telephone:* | | | | | | | | | | *Other Telephone Contact:* | | | | | |
| 1. **Insurance Information:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medicaid #**: | | | |  | | | | | | | | | | | | If Carolina ACCESS, list Primary Care Physician: | | | | | | | | | | | | | | |
| Eligibility Date: | | | |  | | | Expiration Date: | | | | |  | | | | | | | | | PrimaryOther policy in effect (see below) | | | | | | | | | |
| **Primary Policy** : | | | Individual Group HMO/PPO Military Insurance | | | | | | | | | | | | | | **Secondary Policy**: | | | | | | Individual Group HMO/PPO Military Insurance | | | | | | | |
| Insurance Name: | | |  | | | | | | | | | | | | | | Insurance Name: | | | | | |  | | | | | | | |
| Employer/Group: | | |  | | | | | | | | | | | | | | Employer/Group: | | | | | |  | | | | | | | |
| Policy#/ Ins. ID#: | | |  | | | | | | | | | | | | | | Policy #/ Ins. ID#: | | | | | |  | | | | | | | |
| Group ID #: | | |  | | | | | | | | | | | | | | Group ID #: | | | | | |  | | | | | | | |
| Effective Date: | | |  | | | | | | | | | | | | | | Effective Date: | | | | | |  | | | | | | | |
| Claims Phone #: | | |  | | | | | | | | | | | | | | Claims Phone #: | | | | | |  | | | | | | | |
| Claims Address: | | |  | | | | | | | | | | | | | | Claims Address: | | | | | |  | | | | | | | |
| City: |  | | | | | | | State: | | | | Zip: | | | | | City: | |  | | | | | | | State: | | | Zip: | |
| Subscriber Name: | | | | |  | | | | | | | | | | | | Subscriber Name: | | | | | | |  | | | | | | |
| Subscriber Relationship to Client: | | | | |  | | | | | | Subscriber DOB: | | | | | | Subscriber Relationship to Client: | | | | | | |  | | | | Subscriber DOB: | | |
| Subscriber is Guarantor: | | | | | Yes  No | | | | | | Gender:  Male  Female | | | | | | Subscriber is Guarantor: | | | | | | | Yes  No | | | | Gender:  Male  Female | | |
| Subscriber Address: | | | | |  | | | | | | | | | | | | Subscriber Address: | | | | | | |  | | | | | | |
| Health Reimbursement Account attached to primary policy. | | | | | | | | | | | | | | | | | Health Reimbursement Account attached to primary policy. | | | | | | | | | | | | | |
| Health Spending Account attached to primary. **(ENSURE auto draft disabled!)** | | | | | | | | | | | | | | | | | Health Spending Account attached to primary. **(ENSURE auto draft disabled!)** | | | | | | | | | | | | | |
| **In Network Benefits** | | | | | | | | | | | | | | | | | **In Network Benefits** | | | | | | | | | | | | | |
| **Lifetime Cap:** | | Yes  No | | | | | | | **LT Cap Amt.** | | | | |  | | | **Lifetime Cap:** | | | | | Yes  No | | | | | **LT Cap Amt.** | | |  |
| Coinsurance: | |  | | | | | | | Co-Pay: | | | | |  | | | Coinsurance: | | | | |  | | | | |  | | |  |
| Deductible: | |  | | | | | | | Amt. Met: | | | | |  | | | Deductible: | | | | |  | | | | | Amt. Met: | | |  |
| **OUT of Network Benefits** | | | | | | | | | | | | | | | | | **OUT of Network Benefits** | | | | | | | | | | | | | |
| **Lifetime Cap:** | | Yes  No | | | | | | | **LT Cap Amt.** | | | | |  | | | **Lifetime Cap:** | | | | | Yes  No | | | | | **LT Cap Amt.** | | |  |
| Coinsurance: | |  | | | | | | | Co-Pay: | | | | |  | | | Coinsurance: | | | | |  | | | | | Co-Pay: | | |  |
| Deductible: | |  | | | | | | | Amt. Met: | | | | |  | | | Deductible: | | | | |  | | | | | Amt. Met: | | |  |
| **Is Prior Authorization Required for Evaluations?**  Yes  No | | | | | | | | | | | | | | | | | **Is Prior Authorization Required for Evaluations?**  Yes  No | | | | | | | | | | | | | |
| ***PLEASE LIST THE BENEFITS FOR THE FOLLOWING SERVICES:*** | | | | | | | | | | | | | | | | | ***PLEASE LIST THE BENEFITS FOR THE FOLLOWING SERVICES:*** | | | | | | | | | | | | | |
| Evaluations: | | | | | | | | | | | | | | | | | Evaluations: | | | | | | | | | | | | | |
| Occupational Therapy: | | | | | | | | | | | | | | | | | Occupational Therapy: | | | | | | | | | | | | | |
| Physical Therapy: | | | | | | | | | | | | | | | | | Physical Therapy: | | | | | | | | | | | | | |
| Speech Therapy: | | | | | | | | | | | | | | | | | Speech Therapy: | | | | | | | | | | | | | |
| Other Services: | | | | | | | | | | | | | | | | | Other Services: | | | | | | | | | | | | | |
| **Is Prior Authorization Required for Specialized Therapy?**  Yes  No | | | | | | | | | | | | | | | | | **Is Prior Authorization Required for Specialized Therapy?**  Yes  No | | | | | | | | | | | | | |