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| ***北卡罗来纳州婴幼儿计划*** |  |

***保险信息表***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***服务提供方负责保险信息的核实。本表所含信息并不能保证支付保险金。*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **儿童信息：** | | | | | | | | |  | |  | | | | | | | | *ITP SFS %* | | | | | *Monthly*  *Maximum Cap* | | | *Date Completed* | |
|  | | | | | | | | |  | |  | | | | | | | |  | | | | |  | | |  | |
| *孩子的名字* | | | | | | | | | *中名/后缀* | | | *孩子的姓氏* | | | | | | |  | | | | |  | | |  | |
|  | | | | | | | | |  | | | | |  | | |  | |  | | | | |  | | |  | |
| *地址* | | | | | | | | | *市* | | | | | *州* | | | *邮编* | |  | | | | | | | | | |
|  | | | | | | *性别：*  男  女 | | | | | | | |  | | | | | | | | | |  | | | | |
| *出生日期：* | | | | | |  | | | | | | | | *家庭电话：* | | | | | | | | | | *其他电话联系人：* | | | | |
| 1. **保险信息：** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medicaid 编号**： | | | |  | | | | | | | | | | | 如果是 Carolina ACCESS，请列出初诊医师： | | | | | | | | | | | | | |
| 合格日期： | | | |  | | | 到期日期： | | | |  | | | | | | | | | 主保单其他有效保单（见下文） | | | | | | | | |
| **主保单：** | | 个人  团体  HMO/PPO  军人保险 | | | | | | | | | | | | | | **次保单：** | | | | | | 个人  团体  HMO/PPO  军人保险 | | | | | | |
| 保险名称： | |  | | | | | | | | | | | | | | 保险名称： | | | | | |  | | | | | | |
| 雇主/团体： | |  | | | | | | | | | | | | | | 雇主/团体： | | | | | |  | | | | | | |
| 保单号/保险号： | |  | | | | | | | | | | | | | | 保单号/保险号： | | | | | |  | | | | | | |
| 团体编号： | |  | | | | | | | | | | | | | | 团体编号： | | | | | |  | | | | | | |
| 生效日期： | |  | | | | | | | | | | | | | | 生效日期： | | | | | |  | | | | | | |
| 索赔电话号码： | |  | | | | | | | | | | | | | | 索赔电话号码： | | | | | |  | | | | | | |
| 索赔地址： | |  | | | | | | | | | | | | | | 索赔地址： | | | | | |  | | | | | | |
| 城市： |  | | | | 州： | | | | | | 邮编： | | | | | 城市： | |  | | | | | 州： | | | | 邮编： | |
| 投保人姓名： | | |  | | | | | | | | | | | | | 投保人姓名： | | | | |  | | | | | | | |
| 投保人与被保人的关系： | | |  | | | | | | | 投保人出生日期： | | | | | | 投保人与被保人的关系： | | | | |  | | | | | 投保人出生日期： | | |
| 投保人是担保人： | | | 是  否 | | | | | | | 性别： 男  女 | | | | | | 投保人是担保人： | | | | | 是  否 | | | | | 性别： 男  女 | | |
| 投保人地址： | | |  | | | | | | | | | | | | | 投保人地址： | | | | |  | | | | | | | |
| 主保单所附医疗报销账户。 | | | | | | | | | | | | | | | | 主保单所附医疗报销账户。 | | | | | | | | | | | | |
| 主保单所附医疗开支账户。**（请务必禁用自动草稿功能！）** | | | | | | | | | | | | | | | | 主保单所附医疗开支账户。**（请务必禁用自动草稿功能！）** | | | | | | | | | | | | |
| **网内保额** | | | | | | | | | | | | | | | | **网内保额** | | | | | | | | | | | | |
| **终身 (LT) 上限：** | | | 是  否 | | | | | **LT 保额上限** | | | | |  | | | **终身 (LT) 上限：** | | | | | | 是  否 | | | **LT 保额上限** | | |  |
| 共同保险： | | |  | | | | | 共同支付： | | | | |  | | | 共同保险： | | | | | |  | | |  | | |  |
| 免赔额： | | |  | | | | | 达到金额： | | | | |  | | | 免赔额： | | | | | |  | | | 达到金额： | | |  |
| **网外保额** | | | | | | | | | | | | | | | | **网外保额** | | | | | | | | | | | | |
| **终身上限：** | | | 是  否 | | | | | **LT 保额上限** | | | | |  | | | **终身上限：** | | | | | | 是  否 | | | **LT 保额上限** | | |  |
| 共同保险： | | |  | | | | | 共同支付： | | | | |  | | | 共同保险： | | | | | |  | | | 共同支付： | | |  |
| 免赔额： | | |  | | | | | 达到金额： | | | | |  | | | 免赔额： | | | | | |  | | | 达到金额： | | |  |
| **评估是否需要事先授权？**  是  否 | | | | | | | | | | | | | | | | **评估是否需要事先授权？**  是  否 | | | | | | | | | | | | |
| ***请列出以下服务的保额：*** | | | | | | | | | | | | | | | | ***请列出以下服务的保额：*** | | | | | | | | | | | | |
| 评估： | | | | | | | | | | | | | | | | 评估： | | | | | | | | | | | | |
| 职业治疗： | | | | | | | | | | | | | | | | 职业治疗： | | | | | | | | | | | | |
| 物理治疗： | | | | | | | | | | | | | | | | 物理治疗： | | | | | | | | | | | | |
| 言语治疗： | | | | | | | | | | | | | | | | 言语治疗： | | | | | | | | | | | | |
| 其他服务： | | | | | | | | | | | | | | | | 其他服务： | | | | | | | | | | | | |
| **专业治疗是否需要事先授权？**  是  否 | | | | | | | | | | | | | | | | **专业治疗是否需要事先授权？**  是  否 | | | | | | | | | | | | |