NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION
CHILD INSURANCE INFORMATION

Child Name: _____ **DOB:** _____ **Gender:** ☐ **male** ☐ **female**

Primary Insurance Information:

Insurance Company/Plan Name: _____
Insurance Company Billing Address: _____
Policy Identification (ID) Number: _____
Child's Member ID (if different): _____
Group #: _____
Policy Holder Name: _____ Gender: ☐ male ☐ female
Policy Holder DOB: _____
Policy Holder Address: _____
Policy Holder Phone Number: _____
Policy Holder Relationship to child: _____ Policy Effective Date: _____

Other Insurance (if applicable):

Insurance Company/Plan Name: _____
Insurance Company Billing Address: _____
Policy Identification (ID) Number: _____
Child's Member ID (if different): _____
Group #: _____
Policy Holder Name: _____ Gender: ☐ male ☐ female
Policy Holder DOB: _____
Policy Holder Address: _____
Policy Holder Phone Number: _____
Policy Holder Relationship to child: _____ Policy Effective Date: _____

Medicaid Client Identification Number (CIN) (if applicable): ____ ____ ____ ____ ____ ____ ____ ____
(2 letters, 5 numbers, 1 letter)

_____ _____
Parent/Legal Guardian Signature Date

Insurance information must be reviewed at least every six months:

Insurance Info Reviewed at 6 month IFSP:	date _____	no changes_____	SC initial _____
Insurance Info Reviewed at 12 month IFSP:	date _____	no changes_____	SC initial _____
Insurance Info Reviewed at 18 month IFSP:	date _____	no changes_____	SC initial _____
Insurance Info Reviewed at 24 month IFSP:	date _____	no changes_____	SC initial _____
Insurance Info Reviewed (other):	date _____	no changes_____	SC initial _____

PARENT ATTESTATION OF NO INSURANCE (if applicable)

Child Name: _____ **Child's DOB:** _____

I _____ (please print name) the parent and/or legal guardian of the child whose name is above, attest that as of the today's date such child does not have health insurance coverage. I understand that the assigned Early Intervention Program service coordinator must assist me with the identification of and application for health insurance for which such child may be eligible. I also understand that such child is not required to have health insurance in order for Early Intervention Services to be provided.

_____ _____
Parent/Legal Guardian Signature Date