



BabyNet

South Carolina's Early Intervention System

Insurance Resources / Consent to Bill

Intake (initial completion) Date _____

Update # _____ Date _____

1. Child's Name _____ Date of Birth _____

2. PRIVATE INSURANCE RESOURCES (PRIMARY)

Policy Holder Information

Name _____

Relationship to Child _____

Street _____

Telephone _____

City, State, Zip _____

Insurance Company/Policy Information

Name _____

Policy # _____

Address _____

Member/ID#: _____

Group/Acct #: _____

Telephone _____

Effective Date: _____

Termination Date: _____

Plan (check all that apply)

Employer

Self Purchase

HMO

PPO Policy

3. PRIVATE INSURANCE RESOURCES (SECONDARY)

Policy Holder Information

Name _____

Relationship to Child _____

Street _____

Telephone _____

City, State, Zip _____

Insurance Company/Policy Information

Name _____

Policy # _____

Address _____

Member/ID#: _____

Group/Acct #: _____

Telephone _____

Effective Date: _____

Termination

Date: _____

Plan (check all that apply)

Employer

Self Purchase

HMO

PPO

SCFS/BN004 Expires 30jun10



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4. MEDICAID

Currently Enrolled Medicaid # _____

Application Pending Date submitted _____

5. CONSENT TO BILL FOR BABYNET SYSTEM SERVICES

BabyNet requests families served by BabyNet to support the system by giving BabyNet system providers (state agencies and private providers) permission to bill Medicaid and/or private insurance companies for covered services. This request is made in order to be sure that BabyNet funds can serve the largest number of children possible. **This consent is voluntary.**

Please check each box that applies, and sign to give permission to bill Medicaid and/or your insurance. Your signature indicates that you agree to the terms of this consent and allow BabyNet providers to bill and accept payment from your child's health insurance plan(s).

Consent to bill Medicaid. My signature below indicates that:

- I give permission for state agency and/or private sector providers of BabyNet system services to bill Medicaid for covered services and to exchange of information necessary to secure Medicaid payment for these services. (Such necessary information may include my child's diagnosis, service dates, types of services, and other information related to BabyNet system services necessary to process claims.)
- I will notify my BabyNet Service Coordinator of any changes in my child's Medicaid enrollment status.

Parent Signature: _____ Date: _____

Consent to bill insurance plan(s). My signature below indicates that:

- I give permission for state agency and/or private sector providers of BabyNet system services to bill the insurance company(ies) listed above for covered services; and to exchange of information necessary to secure payment for these services. (Such necessary information may include my child's diagnosis, service dates, types of services, and other information related to BabyNet system services necessary to process claims.)
- I understand that if an insurance payment is made directly to me for BabyNet services, I am responsible for immediately sending such payments to the BabyNet provider who delivered the service.
- I will notify my BabyNet Service Coordinator of any changes to my child's health insurance coverage, as well as any denial information.

Signature(s) of individual(s) holding authority to authorize insurance payment.		Date
_____		_____
_____		_____
_____		_____
_____		_____

Intake/Service Coordinator _____ Date _____



INSTRUCTIONS

Insurance Resources / Consent to Bill

A. PURPOSE

The purpose of this form is to obtain consent to utilized private insurance and bill Medicaid as well as when insurance/Medicaid information changes.

B. USES

This form is to be completed by the Intake/Service Coordinator (or designee) during the intake process. The information on this form must be reviewed annually. A new form must be completed whenever there is change in insurance coverage.

C. Instructions

1. Check box to indicate initial completion or updated form. Enter “#1” for first update after initial completion and so on.
2. Enter child’s name and date of birth. (If using BabyTrac generated label with identifying information, place in lower right had corner.)
3. Insurance resources (primary policy)
Enter information as indicated from the insurance card or policy.
4. Insurance resources (secondary policy)
Same as above.
5. Medicaid.
Enter Medicaid number from the current Medicaid card if child is enrolled. If parent has applied for Medicaid, indicate approximate date of application if known.
6. Consent to bill.
 - a. Request parental consent to bill private insurance and/or Medicaid for covered BabyNet system services. Although BabyNet funds should serve payment source of last resort, family consent to bill is voluntary. Parents should be encouraged to consent to third party billing in order to maximize use of BabyNet resources.
 - b. Parents must consent separately for Medicaid and private third party insurance billing by signing and dating appropriate sections of the form.
 - c. Consent for Medicaid billing may be given if application is pending.
 - d. If the child has private health insurance, the individual(s) with authority to authorize the insurance payment must sign the consent form authorizing BabyNet to bill insurance.
7. The Intake/Service Coordinator signs below the parent’s signature.