



Insurance Resources/ Consent to Bill

The BabyNet Program provides services to eligible children paid for by a combination of state and federal funds and reimbursement from private health insurance and Medicaid. In order for private insurance to be billed, parent must provide consent.

1. Child's Name:		Date of Birth:	
2. <input type="checkbox"/> Initial Completion Date:		<input type="checkbox"/> Review Date:	
3. Consent to bill insurance plan(s): <input type="checkbox"/> I give permission for state agency and/or private providers of the BabyNet system of services to bill the insurance company (ies) listed below for covered services, and to exchange 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 needed to process claims.) <input type="checkbox"/> 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. <input type="checkbox"/> I will notify my BabyNet Service Coordinator of any changes to my child's health insurance or Medicaid coverage, including denial information. <input type="checkbox"/> I do not give consent for BabyNet and/or private providers to bill my insurance company.			
Parent Signature: Date:			
4. Primary Insurance		5. Secondary Insurance	
Policy Holder Name:		Policy Holder Name:	
Relationship to Child:		Relationship to Child:	
Policy Holder's Address:		Policy Holder's Address:	
Insurance Company:		Insurance Company:	
Phone Number:		Phone Number:	
Claim Address:		Claim Address:	
Member Number:	Plan Name:	Member Number:	Plan Name:
Group Number:	Effective Date:	Group Number:	Effective Date:
Employer:		Employer:	
Address:		Address:	

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6. Medicaid

Federal Law requires that Medicaid be used for eligible children.

Child's Medicaid Number:

Check one: Medicaid Fee For Service
 Managed Care Organization (MCO)
 Medical Home Network
 TEFRA

Application in process:
 Medicaid Fee For Service
 Managed Care Organization (MCO)
 Medical Home Network
 TEFRA

Plan Eligibility Date:

Date of Application:

Plan Name: _____

Plan Address: _____

Plan Phone Number: _____

Parent Signature: _____

Date: _____

7. I verify that my child is **not** covered by private health insurance or Medicaid at this time.

Parent Signature: _____

Date: _____

8. Service Coordinator Signature: _____

Date: _____

Agency: _____