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| *North Carolina Infant-Toddler Program* |       |

*Insurance Information Worksheet*

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| ***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: |       | **[ ]** Primary **[ ]** Other 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 |