Connecticut Birth to Three System Insurance Information Collection and Consent

The System is funded by a combination of state and federal funds, Medicaid, and private health insurance to support as many families as possible.

SECTION 1

Child's Name: _____ **Birth to Three #:** _____ **Date of Birth:** _____

SECTION 2 – Disclosures Regarding the Birth to Three System ("B23") of System of Payments ("SOP") – I understand:

- I am not required to enroll in HUSKY or private health insurance to receive B23 services.
- My health insurance plan may be exempt from CT insurance mandates. The Affordable Care Act may prevent my plan from adversely affecting my protection, such as applying payments against maximum annual or lifetime limits of the policy.
- I am responsible for paying my insurance premium costs charged by my private health insurance provider.
- If I have an HRA or HSA set up to auto-withdrawal out-of-pocket expenses related to an insurance claim and if I consent to the B23 System or provider billing my insurance and sharing my information, funds may be withdrawn. I may be able to change the auto-withdrawal feature by contacting my insurance company and/or employer.
  - If funds are unintentionally withdrawn from my HSA/HRA for B23 claims, I can work with my service coordinator to submit a request for these funds to be returned to me.
- If private insurance reimbursement is sent directly to me, I must provide that payment to B23.
- If my child has HUSKY A or C and private insurance, I must provide consent to B23 or provider to bill my private insurance first.
- I must notify my service coordinator if I secure new insurance.
- My consent is voluntary and remains in effect unless it is revoked in writing. Such revocation does not apply to shared or released information.
- My consent must be obtained if there is an increase in the frequency, length, duration, or intensity in my child's Individualized Family Service Plan ("IFSP").
- My child and family will receive an evaluation and, if eligible: an assessment, IFSP, and the specific B23 services and supports without delay or denial regardless of whether I provide consent to bill insurance and release information.
- If I choose to participate in B23 and my child is enrolled in HUSKY A or C, claims will be submitted and our Protected Health Information ("PHI") and Personally Identifiable Information ("PII") will be shared for the purpose of billing.

SECTION 3 – Health Insurance

Required: Does my child have health insurance?

☐ **YES**, my child is covered by health insurance. *Go to next section*

☐ **NO**, my child is not covered by health insurance. I understand that I am not required to enroll in Medicaid or private health insurance to receive services. *Go to Section 6*

SECTION 4 – HUSKY A or C Coverage (Medicaid)

Required: Is my child covered by HUSKY A or C insurance? (For HUSKY B, check "NO" and go to Section 5.)

☐ **NO** HUSKY A or C – *Go to next section*

☐ **YES** – *Complete below and go to next section*

HUSKY # (9 digits): _____ **Name on card (if different):** _____

SECTION 5 – Private Insurance or HUSKY B

Required: Is my child covered by commercial/private health insurance or HUSKY B?

☐ **NO** – *Go to Section 6* ☐ **YES** – *Complete this section and go to Section 6*

Do you understand, agree, and consent to allowing B23 and/or its assigned program to (1) bill your child's private health insurance (2) share and release claims to your child's insurance, and (3) disclose or exchange your and your child's PHI and PII for the purpose of billing for B23 services? Providing consent is optional and not required. See Section 2 for details.

☐ **YES**, I do agree and consent – Please provide insurance details for all health insurance plans – *Go to next section*

☐ **NO**, I do not agree or consent – *Go to next section*

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Child's Name: _____ Birth to Three #: _____ Date of Birth: _____

SECTION 5 – Private Insurance or HUSKY B (Continued)

Primary Insurance:

Insurance Name: _____ Member Number: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Secondary Insurance:

Insurance Name: _____ Member Number: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

SECTION 6 – Acknowledgement and Understanding

I received a copy of the Parent Rights and SOP documentation, also available online, at www.birth23.org. The documentation includes dispute resolution options if I disagree with any decisions made within B23, including billing HUSKY or private insurance.

Initial: _____ *Go to next section*

SECTION 7 – Informed Consent

I understand and agree with the provisions outlined in Sections 2, 5, and 6. Based on my response in Section 5, I acknowledge the following:

- If I provide consent, I authorize B23 and/or its assigned program to bill my child's private health insurance or HUSKY B and to access related insurance or public benefits for the purpose of paying for IDEA Part C services at no cost to me. I further consent to the sharing and release of all educational and medical information necessary to process insurance claims, including records maintained by B23. If my child is found eligible, insurance claims may also include services listed on my child's IFSP. I understand that I will not be responsible for any out-of-pocket expenses, including co-pays and deductibles. If I revoke consent at any time, the state will continue to provide all IDEA Part C services listed on the IFSP for which I have provided consent, without billing my insurance and at no cost to me.
- If I do not provide consent, I understand that B23 will not bill my private health insurance or HUSKY B. My child will still receive all IDEA Part C services listed on the IFSP for which I have provided consent, at no cost to me.

For additional details regarding insurance requirements, billing practices, and consent provisions, I refer to Section 2: Disclosures Regarding B23 and SOP.

First and Last Name: _____ **Date:** _____

Signature: _____

SECTION 8 – Revocation - USE ONLY IF NEEDED FOR PRIVATE INSURANCE AND HUSKY B

As of the date of my signature below, I hereby revoke consent for the billing, sharing, and release of educational and medical information necessary to process insurance claims on behalf of my child. I understand and agree that if I revoke, the state will still make available those IDEA Part C services on the IFSP to which I have provided consent. I understand and agree that revocation does not apply to already released information.

First and Last Name: _____ **Date:** _____

Signature: _____

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