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| Child’s Name | | Birth to Three # |
| Date of Birth: | Birth to Three Program Name | Program Phone #: |

*To support as many families as possible, the Connecticut Birth to Three System is funded by a combination of state and federal funds, Medicaid, and private health insurance. (See Form 1-3a as applicable.)*

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| Federal and state statutes and regulations state: (1) the CT Birth to Three System will not disclose any personally identifiable information for billing public/private insurance without parental consent, (2) the state will not collect co-pays or deductibles required by the insurance company, (3) reimbursement from insurance will not exceed the state’s cost for services, (4) parents are not required to sign up for, or enroll in public or private health insurance in order to receive services, (5) parents can withdraw consent to bill insurance at any time, (6) enrollment in Birth to Three will not adversely affect the availability of health insurance to the child, child’s parent or child’s family members, (7) billing will not result in increased premiums or discontinuation of public or private insurance benefits for the child or the child’s family.  **Exceptions to Above State Statute on Billing Private Health Insurance:** Some private insurance plans are not required to follow CT state mandates as listed above (e.g. plans that are self-funded by an employer, also called ERISA plans, plans written by companies that do not sell health insurance in CT, or out of state policies). These non-mandated plans may or may not pay claims for Birth to Three services, or may affect other protections above (See Form 1-3a). | | | | |
| **Child’s Medicaid Number**: Husky 🞏 A 🞏 B # \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | | | | |
| **Primary Insurance Company Name:** | | Claim Address: | | |
| Phone: | | Effective Date: | | |
| Member Number: | | Group Number: | | |
| Employer: | | Employer’s Address: | | |
| Primary Policy Holder’s Name: | DOB: | | Relationship to Child: | Mailing Address: |
| Is Primary Policy Holder’s address same as home address? **🞏** Yes **🞏** No | | | | |
| **Secondary Insurance Company Name:** | | Claim Address: | | |
| Phone: | | Effective Date: | | |
| Member Number: | | | Group Number: | |
| Employer: | | Employer’s Address: | | |
| Secondary Policy Holder’s Name: | DOB: | | Relationship to Child: | Mailing Address: |
| Is Secondary Policy Holder’s address same as home address? 🞏Yes 🞏No | | | | |
| ⬩ Is plan(s) non-mandated? 🞏Yes 🞏No If Yes, complete Form 1-3a  *⬩* Is there a health savings account?🞏Yes 🞏No HSA will not be billed without a signed Form 1-3-HSA | | | | |

**\_\_\_\_**I authorize the release of medical or other information necessary to process claims to my insurance carrier or federal Centers for Medicare & Medicaid Services on behalf of my child, who is being evaluated and as a result may be enrolled in the Connecticut Birth to Three System. I understand that if payment for Birth to Three services is sent to me directly, I must send that payment to my Birth to Three program. I also understand that I can withdraw this consent at any time.

**\_\_\_\_**I do not authorize the release.

**\_\_\_\_** I have no insurance.

**Print** Name Signature Date

**\_\_\_\_\_** Consent Revoked on \_\_\_\_\_\_\_\_\_\_\_\_\_\_(date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(signature)

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| --- | --- |
| Information reviewed by: | Signature of Birth to Three representative/Date |