SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections BABYNET

CONSENT TO USE INSURANCE RESOURCES

SECTION 1: CHILD AND PARENT INFORMATION

Child's Name:	Date of Birth:	BRIDGES ID #:
Parent's Name:	Date: Completed:	Review Date:

SECTION 2: MEDICAID COVERAGE:
☐ **YES IF YES, COMPLETE SECTION 2** ☐ **NO IF NO, PROCEED TO SECTION 3**

The Individuals with Disabilities Education Act (IDEA) requires that Medicaid be billed for services on your Individualized Family Service Plan if your child is eligible both for IDEA/Part C and Medicaid benefits. You are not required to apply for Medicaid benefits as a condition of IDEA/Part C eligibility.

Child's Medicaid Number:

Name of Medicaid Managed Care Organization (MCO)(if applicable):

Signature of Parent *Date*

SECTION 3: PRIVATE HEALTH INSURANCE COVERAGE:
☐ **YES IF YES, COMPLETE SECTION 3 AND 4** ☐ **NO IF NO, PROCEED TO SECTION 5**

NOTE: If you have private insurance **and** Medicaid, you **must** give consent to bill your private insurance for services on your Individualized Family Service Plan, and initial 'Yes' to all acknowledgements and consents below.

Parent Initials		Acknowledgements and Consents
Yes	**No**	
		I have received a copy of the Written Notice Related to Private Insurance/Medicaid and System of Payment Policies, as well as the Parent Notice of Family Rights and Safeguards.
		I give permission for Early Intervention Service (EIS) Providers to bill the insurance company(ies) listed below for services on my child's Individualized Family Service Plan (IFSP), and to exchange information (e.g. diagnosis, service dates, types of service, etc.) necessary to secure payment for these services. I understand that IDEA/Part C will cover most co-payments, financial responsibility associated with any deductibles, and other co-insurance associated with the services on my child's IFSP but does not assume responsibility for payment of my health insurance premiums. I understand that this consent applies to all services on my IFSP unless otherwise noted.
		I understand that if an insurance payment is made directly to me for IDEA/Part C services, I am responsible for immediately sending such payments to the EIS provider who delivered the service.
		I will immediately notify my Service Coordinator of any changes to my child's health insurance or Medicaid coverage.
		I understand that my Service Coordinator is responsible for making sure the EIS providers on my IFSP receive a copy of this form and will update the data system to notify EIS providers of any changes to my child's health insurance/Medicaid coverage.

Signature of Parent *Date*

SECTION 4: PRIVATE INSURANCE INFORMATION AND CONSENT EXCEPTIONS			
PRIMARY INSURANCE		**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:	

PRIVATE INSURANCE ONLY: If there are any services you do <u>not</u> want billed to your private insurance, please list the service(s) and initial below.

IDEA/PART C SERVICES ON MY IFSP	PARENT INITIALS

SECTION 5: NO INSURANCE COVERAGE:

My child <u>is not covered by private health insurance or Medicaid at this time</u> and I agree to inform my Service Coordinator of any changes to my child's health insurance or Medicaid coverage as they occur.

Signature of Parent	*Date*

SECTION 6: SERVICE COORDINATOR SIGNATURE AND AGENCY:

Signature of Service Coordinator	*Date*
Service Coordination Agency	