



PRIVATE MEDICAL INSURANCE SUPPLEMENT

State Form 51309 (R2 / 4-06) / BCD 0086

Division of Disability and Rehabilitative Services



Effective May 01, 2006

To be completed for all children who are covered by private health insurance.

Attach a copy of the front and back of the insurance card.

Name of child (<i>last, first, middle initial</i>)		Date of birth (<i>month, day, year</i>)
Child ID		County
Name of Service Coordinator	Telephone number ()	Fax number ()
INSURANCE INFORMATION		
Name of insurance carrier		
Date coverage started (<i>month, day, year</i>)		Date coverage ended (<i>month, day, year</i>)
Group name		If the plan has a GROUP number, you must have a member number / ID. You may or may not have a Group name. If the plan has a POLICY ID, you may or may not have a group name or number
Group number		
Policy / member ID		
Policy billing order (<i>check one, please complete an additional form for a secondary insurance</i>) <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> Unknown		
Type of insurance (MUST CHOOSE AT LEAST ONE)		
<input type="checkbox"/> Consolidated Omnibus Budget Reconciliation Act (COBRA)	<input type="checkbox"/> Medicaid	
<input type="checkbox"/> Disability	<input type="checkbox"/> Personal	
<input type="checkbox"/> Disability Benefits	<input type="checkbox"/> Personal Payment (<i>cash - no insurance</i>)	
<input type="checkbox"/> Exclusive Provider Organization	<input type="checkbox"/> Point of Service	
<input type="checkbox"/> Group Policy	<input type="checkbox"/> Preferred Provider Organization (PPO)	
<input type="checkbox"/> Health Maintenance Organization (HMO)	<input type="checkbox"/> OTHER: As indicated on page two (2) of this form	
<input type="checkbox"/> Individual Policy		
POLICY HOLDER INFORMATION (<i>family subscriber</i>)		
Name of policy holder (<i>last, first, middle initial</i>)		Telephone number ()
Relationship to child (<i>check one</i>) <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Other: _____		Employer tax ID
Address (<i>number and street</i>)		
City	State	ZIP code
Date of birth (<i>month, day, year</i>)		Social Security number of policy holder
The information I have provided is complete and correct to the best of my knowledge. I will notify the First Steps Service Coordinator if there are any changes in my insurance or insurance coverage.		
Signature of parent		Date (<i>month, day, year</i>)
Signature of Intake / Service Coordinator		Date (<i>month, day, year</i>)

DISTRIBUTION: Original - SPOE EI file; Copy - Parent, Service Coordinator

COMPLETE LISTING FOR TYPE OF INSURANCE:

If OTHER is checked on the front page of this form, please indicate which insurance type applies toward coverage.

- Medicare Secondary, End-Stage Renal Disease Beneficiary in the 12 month coordination period
- Medicare Secondary, Working Aged Beneficiary or Spouse with Employer Group Health Plan
- Medicare Secondary, No-fault Insurance including Auto is Primary
- Medicare Secondary, Worker's Compensation
- Medicare Secondary, Public Health Service (PHS) or other Federal Agency
- Medicare Secondary, Black Lung
- Medicare Secondary, Veteran's Administration
- Medicare Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- Medicare Secondary, Other Liability Insurance is Primary
- Auto Insurance Policy
- Commercial
- Medicare Conditionally Primary
- Health Maintenance Organization (HMO) - Medicare Risk
- Special Low Income Medicare Beneficiary
- Indemnity
- Long Term Care
- Long Term Policy
- Life Insurance
- Litigation
- Medicare Part A
- Medicare Part B
- Medigap Part A
- Medigap Part B
- Medicare Primary
- Other
- Property Insurance - Personal
- Qualified Medicare Beneficiary
- Property Insurance - Real
- Supplemental Policy
- Tax Equity Fiscal Responsibility Act (TEFRA)
- Workers Compensation
- Wrap Up Policy