PRIVATE HEALTH INSURANCE AUTHORIZATION FORM
FOR PART C SERVICES

CHILD'S INFORMATION

CHILD'S NAME_____ BIRTHDATE_____/_____/_____

PRIVATE HEALTH INSURANCE POLICY NUMBER_____

PARENT'S NAME_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHYSICIAN'S NAME_____ PHONE _____

ADDRESS_____

CITY _____ STATE _____ ZIP:_____

(Please initial one)

_____**I give my consent.** I give my consent for Birth to Three Connections providers to submit claims to my private health insurance for covered services. I authorize my private health insurance to make these payments to the Birth to Three Connections provider. I authorize the release of any information from the Birth to Three Connections provider to my private health insurance as necessary to request payment of benefits. I understand these costs may count against the lifetime cap of my private health insurance. I understand that I may revoke this permission at any time by notifying my Birth to Three Connections Service Coordinator.

_____**I do not give my consent**.

I understand that all services will be provided to my child, without delay, without regard to public or private health insurance coverage status during the time frame of the IFSP. If the level of services increases during the duration of the IFSP, a new consent authorization form must be signed. Services to be provided are documented in child's IFSP.

_____ _____
Signature of Parent or Guardian Date