

# Tips to Completing the Health Insurance Authorization Form

Explain *Funding in Early Intervention*.

Examine insurance card(s).

If the child has one insurance card always ask if there is other insurance.

## RI Medicaid section

- If the child has more than one insurance and 1 card is RI Medical Assistance
  - Record info from both cards in RI Medicaid section (No consent needed)
  - If Rlte Care record in Rlte Care lines. If not Rlte Care record on Private Insurance line
  - If the child has Rlte Care check if it is United or Neighborhood and record info in RI Medicaid section (No consent needed)
    - United Health Community Plan (says Rlte Care in bottom right corner)
    - NHP (green wavy stripe on bottom and plan is called ACCESS)
- If the child has 1 card and it is RI Medical Assistance:
  - Record information in the RI Medicaid section (No consent needed) This is a temporary situation the child will shortly be enrolled in either a Rlte Care or a private plan. Check and update information in the RI Medicaid section (no consent is required)

## Private Insurance section

- If the child has one card and it is not Rlte Care or RI Medical Assistance it is Private Insurance. Record information in the Private Insurance section of the form and obtain consent.
- If the child has more than one card and neither are RI Medical Assistance or Rlte Care, the child has double coverage by two private insurers. Record all information in the Private Insurance section and obtain consent.


# Example: NHP Rite Care

Program Information		Rhode Island Early Intervention Health Insurance Consent to Release Information			
<b>CHILD INFORMATION</b>					
Child's Last Name: <b>Sample</b>	First: <b>Howard</b>	Date of Birth <b>05/01/2013</b>	Child ID# <b>1872014</b>		
<b>PRIVATE INSURANCE INFORMATION</b>					
Please indicate primary insurance. If primary or secondary insurance is Rhode Island Medicaid see that section below.					
<input type="checkbox"/> Blue Cross / Blue Shield	<input type="checkbox"/> Neighborhood Health Plan	<input type="checkbox"/> Unitedhealthcare	<input type="checkbox"/> Tufts	<input type="checkbox"/> Other:	
Policyholder's name:	Member number:	Claims address / telephone number:			
Group number (if indicated):	Effective date of coverage ___/___/___				
Please indicate secondary insurance (if applicable)					
<input type="checkbox"/> Blue Cross / Blue Shield	<input type="checkbox"/> Neighborhood Health Plan	<input type="checkbox"/> Unitedhealthcare	<input type="checkbox"/> Tufts	<input type="checkbox"/> Other	
Policyholder's name (if indicated):	Member number:	Claims address / telephone number:			
Group number (if indicated):	Effective date of coverage ___/___/___				
<b>Consent to Release Information</b>					
<input checked="" type="checkbox"/> I give my consent to release information to my insurance carrier for billing purposes. Necessary information may include my child's name, date of birth, policy number, address, diagnosis, service dates, services and other information necessary to process insurance claims. I consent to the release of this information and understand that I may cancel my consent at any given time without losing EI services my child is receiving, by notifying my service coordinator.					
<input type="checkbox"/> I do not give my consent to release information to my insurance carrier for billing purposes.					
Parent/Guardian Signature _____		Date _____			
<b>RHODE ISLAND MEDICAID</b>					
Policyholder's name: <b>Howard Sample</b>		RIte Care Member Number:			
<input type="checkbox"/> RIte Care Unitedhealthcare	RIte Care Member Number: <b>100000100</b>				
<input checked="" type="checkbox"/> RIte Care Neighborhood Health Plan	Member Number:	Claims address / telephone number:			
<input type="checkbox"/> Private Insurance *	Group Number (if indicated):				
<input checked="" type="checkbox"/> RI Medical Assistance	RI Medical Case Number: <b>000-00-0000</b>				
Effective date of coverage ___/___/___					
*If the parents have both Rhode Island Medicaid and private insurance, Rhode Island Medicaid regulations require the use of private insurance as the primary insurance. Complete the Private Insurance lines as well as RI Medical Assistance lines in the Rhode Island Medicaid section					




**ID Number:** 100000100  
**Plan:**

**Member:** Howard Sample



**Primary Care Doctor**  
**Name:** Joseph Smith, MD  
**Site:** Gonzalez Pediatric Associates  
**Phone:** (401) 999-9000 (24 hour service)


**Co-pays:**  
Office Visit: \$  
Specialist Visit: \$  
Pharmacy: \$





- This is an example of an NHP Rite Care plan. ACCESS is the name of the NHP Rite Care plan. The child's RI Medical Assistance card is shown as well as the plan card. No consent to release information is required
- NHP now offers private plans in addition to Rite Care.
- Effective date of coverage can be obtained when verifying insurance with the carrier.

Always ask if the child has any other coverage. Parents of children covered by RI Medicaid are told by Medicaid to always show both the RI Medical Assistance card and their plan card.

## Example: NHP Private Insurance

Program Information		Rhode Island Early Intervention Health Insurance Consent to Release Information			
<b>CHILD INFORMATION</b>					
Child's Last Name: <b>Sample</b>	First: <b>Howard</b>	Date of Birth: <b>12/01/2013</b>	Child ID#: <b>1872014</b>		
<b>PRIVATE INSURANCE INFORMATION</b>					
Please indicate primary insurance. If primary or secondary insurance is Rhode Island Medicaid see that section below.					
<input type="checkbox"/> Blue Cross/ Blue Shield <input checked="" type="checkbox"/> Neighborhood Health Plan <input type="checkbox"/> Unitedhealthcare <input type="checkbox"/> Tufts <input type="checkbox"/> Other:					
Policyholder's name: <b>Howard Sample</b>		Member number: <b>100000100</b>		Claims address/ telephone number:	
Group number (if indicated):		Effective date of coverage __/__/__			
Please indicate secondary insurance (if applicable)					
<input type="checkbox"/> Blue Cross/ Blue Shield <input type="checkbox"/> Neighborhood Health Plan <input type="checkbox"/> Unitedhealthcare <input type="checkbox"/> Tufts <input type="checkbox"/> Other:					
Policyholder's name (if indicated):		Member number:		Claims address/ telephone number:	
Group number (if indicated):		Effective date of coverage __/__/__			
<b>Consent to Release Information</b>					
<input checked="" type="checkbox"/> I give my consent to release information to my insurance carrier for billing purposes. Necessary information may include my child's name, date of birth, policy number, address, diagnosis, service dates, services and other information necessary to process insurance claims. I consent to the release of this information and understand that I may cancel my consent at any given time without losing EI services my child is receiving, by notifying my service coordinator.					
<input type="checkbox"/> I do not give my consent to release information to my insurance carrier for billing purposes.					
<b>Mary Sample</b>		<b>08/01/2014</b>			
Parent/Guardian Signature		Date			
<b>RHODE ISLAND MEDICAID</b>					
Policyholder's name:					
<input type="checkbox"/> Rite Care Unitedhealthcare		Rite Care Member Number:			
<input type="checkbox"/> Rite Care Neighborhood Health Plan		Rite Care Member Number:			
<input type="checkbox"/> Private Insurance *		Member Number:		Claims address/ telephone number:	
		Group Number (if indicated):			
<input type="checkbox"/> RI Medical Assistance		RI Medical Case Number:			
Effective date of coverage __/__/__					
<small>*If the parents have both Rhode Island Medicaid and private insurance, Rhode Island Medicaid regulations require the use of private insurance as the primary insurance. Complete the Private Insurance lines as well as RI Medical Assistance lines in the Rhode Island Medicaid section.</small>					

Always ask if the child has any other coverage. Parents of children covered by RI Medicaid are told by Medicaid to always show both the RI Medical Assistance card and their plan card.


ID Number: 100000100	
Plan:	
Member: Howard Sample	
<b>Primary Care Doctor</b>	<b>Co-pays:</b>
Name: Joseph Smith, MD	Office Visit: \$
Site: Gonzalez Pediatric Associates	Specialist Visit: \$
Phone: (401) 999-9000 (24 hour service)	Pharmacy: \$
	Urgent Care: \$
	ER: \$
<b>VALUE</b> 	

- This NHP card does not say ACCESS therefore It is not Rite Care. This child does not have a RI Medical Assistance card. This is an example of private insurance and consent to release information is required.
- NHP now offers private plans in addition to Rite Care. (e.g., VALUE, CHOICE, PLUS and PREMIER)
- Effective date of coverage can be obtained when verifying insurance with the carrier.

# Example: Private Insurance and RI Medical Assistance-e.g. Rite Share

Parent Information

Rhode Island Early Intervention Health Insurance Consent to Release Information



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**CHILD INFORMATION**

Child's Last Name <b>Brown</b>	First <b>Mary</b>	Date of Birth <b>05/01/2013</b>	Child ID# <b>1872014</b>
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**PRIVATE INSURANCE INFORMATION**

Please indicate primary insurance. If primary or secondary insurance is Rhode Island Medicaid see that section below.

Blue Cross / Blue Shield Health Plan  Neighborhood Health Plan  UnitedHealthcare  Tufts  Other:

Policyholder's name: \_\_\_\_\_ Member number: \_\_\_\_\_ Claims address / telephone number: \_\_\_\_\_

Group number (if indicated): \_\_\_\_\_ Effective date of coverage: \_\_\_\_\_

Please indicate secondary insurance (if applicable)

Blue Cross / Blue Shield Health Plan  Neighborhood Health Plan  UnitedHealthcare  Tufts  Other:

Policyholder's name (if indicated): \_\_\_\_\_ Member number: \_\_\_\_\_ Claims address / telephone number: \_\_\_\_\_

Group number (if indicated): \_\_\_\_\_ Effective date of coverage: \_\_\_\_\_

**Consent to Release Information**

I give my consent to release information to my insurance carrier for billing purposes. Necessary information may include my child's name, date of birth, policy number, address, diagnosis, service dates, services and other information necessary to process insurance claims. I consent to the release of this information and understand that I may cancel my consent at any given time without losing EI services my child is receiving, by notifying my service coordinator.

I do not give my consent to release information to my insurance carrier for billing purposes.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**RHODE ISLAND MEDICAID**

Policyholder's name: **John Brown**

Rite Care UnitedHealthcare  Rite Care Neighborhood Health Plan  Private Insurance \*

United Health	Rite Care Member Number: 999999999	Claims address / telephone number: P.O. Box 740800 Atlanta, Georgia 30374-0800
	Group Number (if indicated): 123456	

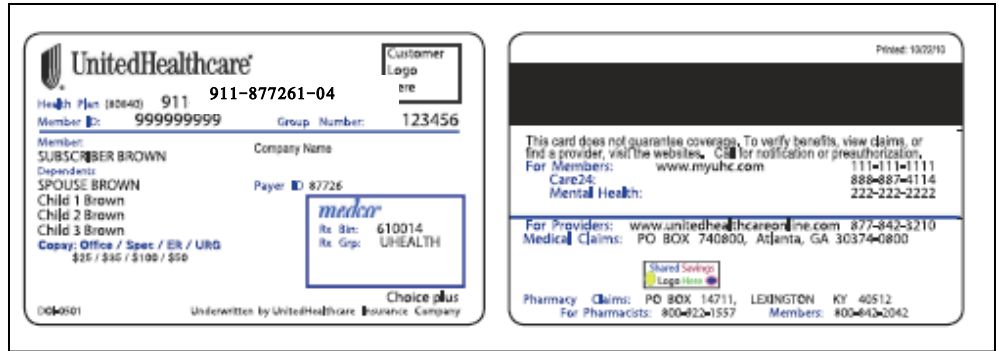
RI Medical Assistance

	RI Medical Case Number: 000-00-0000	
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Effective date of coverage: \_\_\_\_\_

\*If the parent has both Rhode Island Medicaid and private insurance, Rhode Island Medicaid regulations require the use of private insurance as the primary insurance. Complete the Private Insurance lines as well as RI Medical Assistance lines in the Rhode Island Medicaid section.

Form #1007 Rhode Island Early Intervention Health Insurance Consent to Release Information 6/18/2014



- This is an example of a private United Health plan (it does not say Rite Care in the bottom right corner).
- The child also has RI Medical Assistance.
- No consent to release information is required
- Effective date of coverage can be obtained when verifying insurance with the carrier.

Always ask if the child has any other coverage. Parents of children covered by RI Medicaid are told by Medicaid to always show both the RI Medical Assistance card and their plan card.