Program Information

Rhode Island Early Intervention Health Insurance Consent to Release Information and Attestation of Child Income

CHILD INFORMATION

Child's Last Name:	First:	Date of Birth	Child ID#

PRIVATE INSURANCE INFORMATION

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

☐ Blue Cross Blue Shield	☐ Neighborhood Health Plan	☐ United Healthcare	☐ Tufts Health Plan	☐ 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	☐ Neighborhood Health Plan	☐ United Healthcare	☐ Tufts Health Plan	Other:

Policyholder's name (if indicated):	Member number:	Claims address/ telephone number:
Group number (if indicated):	Effective date of coverage:	

Consent to Release Information

With my consent, necessary information will be released to my insurance carrier(s) for billing purposes. Necessary information may include my child's name, date of birth, policy number, address, diagnosis, service details (types of services provided and service dates, starting from the date of referral), and other information necessary to process insurance claims. I understand that I may withdraw my consent at any given time without losing EI services my child is receiving, by notifying my service coordinator.

- ◯ I give consent to release necessary information to my insurance carrier(s) for billing purposes.
- ◯ I do not give my consent to release necessary information to my insurance carrier(s) for billing purposes.

Parent/Guardian Signature Date

RHODE ISLAND MEDICAID INFORMATION

Policyholder's name:		
☐ United Healthcare RIte Care	RIte Care Member Number:	
☐ Neighborhood Health Plan of RI RIte Care	RIte Care Member Number:	
☐ Tufts Health RITogether	RIte Care Member Number:	
☐ Private Insurance *	Member Number:	Claims address/ telephone number:
	Group Number (if indicated):	
RI Medical Assistance	RI Medicaid ID (MID):	
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

ATTESTATION OF CHILD INCOME

The State of RI is able to request federal dollars to match any State dollars spent to provide services to children and families. Your response will in no way impact services provided to you and your child.

- ◯ My child's annual income is **greater than** 300% of the federal social security income
- ◯ My child's annual income is **less than** 300% of the federal social security income.

Parent/Guardian Signature Date

For 2026 the child's annual income would need to be $ ($11,929.46 x 3) in order to exceed 300% of the federal social security income This amount can be determined by going to http://www.ssa.gov/OACT/COLA/SSI.html under annual amount for an eligible individual, times 3.