GCI-1041A FORFF (4-16)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Arizona Early Intervention Program (AzEIP)

**CONSENT TO BILL HEALTH INSURANCE**

I-TEAMS ID CHILD’S NAME *(Last, First, M.I)* DATE OF BIRTH

NAME OF AzEIP TBEIS PROVIDER SERVICE COORDINATOR’S NAME SERVICE COORDINATION AGENCY

My Service Coordinator provided me with a copy of the booklet “A Family’s Guide to Funding Early Intervention Services in Arizona” (GCI-1086A) and informed me of my rights.    [ ]  Yes [ ]  No

My Service Coordinator explained that if I consent to use my health insurance, there will be no out-of-pocket costs to me *(no copays, no deductibles, no fees)* and it will help cover costs of providing early intervention services for my child.   [ ]  Yes [ ]  No

I understand that if I decline the use of my health insurance for AzEIP services, my family will not be denied early intervention services.  [ ]  Yes [ ]  No

[ ]  My child does not currently have health insurance [ ]  I would like to learn how to obtain health insurance

I consent for the Arizona Early Intervention Program (AzEIP), including its providers, to use my:

[ ]  Public insurance (e.g., AHCCCS/CMDP) [ ]  Private insurance

To pay for covered early intervention services. I also consent to the release of any information necessary to file a claim with my health plan. If I receive an Explanations of Benefits and/or payments from my insurance company, I will give them to the provider of services. I understand that if I change my consent in the future, this decision will not affect my family’s early intervention services.

I **do not** consent for the Arizona Early Intervention Program (AzEIP), including its providers, to use my:

[ ]  Public insurance (e.g., AHCCCS/CMDP) [ ]  Private insurance

to pay for covered early intervention services or to release any information necessary to file a claim with my health plan for the following reason(s):

*Parent (IDEA Parent) Date*

*Service Coordinator’s Signature Date*  [ ]  AzEIP Provider [ ]  DDD [ ]  ASDB

*Supervisor’s Signature Date*

**IF CONSENT IS PROVIDED, PLEASE COMPLETE INFORMATION ON REVERSE**

Upon completion send:

To: Department of Economic Security

Arizona Early Intervention Program (AzEIP)

Fax: 602-200-9820  or Secure email: AllAzEIP2@azdes.gov

See reverse for EOE/ADA/LEP/GINA disclosures

GCI-1041A FORFF (4-15) - Reverse

**PRIMARY INSURANCE**

INSURANCE NAME HEALTH PLAN, IF APPLICABLE

MEMBER’S ID NO. EFFECTIVE DATE GROUP NO.

MEMBER’S NAME MEMBER’S DATE OF BIRTH

POLICYHOLDER’S NAME *(If different than member name)* POLICYHOLDER’S EMPLOYER *(If private insurance)*

CLAIMS ADDRESS PHONE NO.

PRIMARY CARE PROVIDER PRIMARY CARE PROVIDER’S PHONE NO.

**SECONDARY INSURANCE**

INSURANCE NAME HEALTH PLAN, IF APPLICABLE

MEMBER’S ID NO. EFFECTIVE DATE GROUP NO.

MEMBER’S NAME MEMBER’S DATE OF BIRTH

POLICYHOLDER’S NAME *(If different than member name)* POLICYHOLDER’S EMPLOYER *(If private insurance)*

CLAIMS ADDRESS PHONE NO.

PRIMARY CARE PROVIDER PRIMARY CARE PROVIDER’S PHONE NO.

For text below see DES ADA Statement JAWS readable.docx.

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