ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

CONSENT TO BILL HEALTH INSURANCE

Child's Name _____ Date of Birth *(MM/DD/YYYY)* _____ I-TEAMS ID _____

Primary Care Physician (PCP) Name* _____ PCP Phone Number* (###) ###-#### _____

Clinic Name, Address, or Cross Streets*

_____

_____

My Service Coordinator, _____, reviewed with me A Family's Guide to Funding Early Intervention Services in Arizona, (GCI-1086A) which describes AzEIP's system of payments.

Parent Initials: _____

I agree the following information or support was provided:

- I was provided a copy or information on how to access A Family's Guide to Funding Early Intervention Services in Arizona, (GCI-1086A) .
- My Service Coordinator informed me of my child and family rights with AzEIP and provided a copy or information on how to access a Child and Family Rights in the Arizona Early Intervention Program, GCI-1070A.
- 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, and no fees), and it will help cover costs of providing early intervention services for my child.
- I understand that if I decline the use of my health insurance for AzEIP services, my family will not be denied early intervention services.
- My Service Coordinator has explained how Early Intervention services are funded in Arizona with AzEIP partner agencies and has explained the benefits and impacts of using my insurance. Not consenting to use my insurance may limit access to other services provided by those partner agencies.
- It was explained to me that I have the right to change my mind about consenting to use my insurance at any time. However, if I withdraw my consent it will not apply to services provided or personal information shared prior to the date of my withdrawal of consent.
- If there are no changes, this consent is valid for one year (12 months) from the date I signed the consent.
- I will need to complete a new Consent to Bill Health Insurance form when there are changes to my insurance.
- I was offered a copy of this completed Consent to Bill Health Insurance form.

Parent Initials: _____

I understand my responsibility to:

- Share a copy of any Explanation of Benefits (EOB) or Notice of Action (NOA) I receive for my child's AzEIP services, upon request.
- Report and forward any payments I receive from my insurance company for my child's AzEIP services to my early intervention provider.
- Contact my insurance company if I need specific information about my child's insurance coverage.

Parent Initials: _____

My selection below indicates that I either voluntarily consent or decline for AzEIP providers, contractors, and subcontractors to bill my insurance plan(s) to pay for covered early intervention services from the date of this consent until it expires or is revoked in writing.

If I agree, I also consent to share my personally identifiable information and early intervention records with my health insurance.

See page 3 for EOE/ADA disclosures

Child's Name _____ Date of Birth *(MM/DD/YYYY)* _____ I-TEAMS ID _____

My decision for each insurance type is listed below:

Private Insurance: ○ I consent ○ I decline ○ N/A - no private insurance plan

Health Savings Account (HSA) *(I understand that if my elected insurance plan automatically uses my HSA, it may be billed for AzEIP services)*: ○ I consent ○ I decline ○ N/A - no HSA plan

Health Reimbursement Agreement (HRA) *(I understand that if my elected insurance plan automatically uses my HRA, it may be billed for AzEIP services)*: ○ I consent ○ I decline ○ N/A - no HRA plan

Public Insurance *(I understand the use of my private insurance is required prior to the use of my public insurance)*: ○ I consent ○ I decline ○ N/A - no public insurance

The reason I decline to use one or more of my insurance plans *(completed by parent)*:

I would like help from my Service Coordinator to learn how to obtain health insurance. ○ Yes ○ No

Digitally Sign

Parent Signature: _____ Date*: _____

PRIMARY INSURANCE TYPE* ***(If applicable)*** ○ **Private** ○ **Public**	
Insurance/Health Plan Name*	Plan Type *(EPO, PPO, HMO, etc.)*
Member's ID or AHCCCS ID*	Insurance Customer Service Phone Number
Policy Number *(If different than above)*	Member's Name *(as written and spelled on insurance card)*
Policyholder's Name *(If different than member name)*	Policyholder's Date of Birth
Policyholder's Employer *(If applicable for group coverage)*	Group Number*
Insurance Claims/Provider Phone Number	Claims Address
Coverage Start Date*	Coverage End Date *(Leave blank if unknown)*
Has the deductible for the year been met? ○ Yes ○ No ○ Not sure ○ No deductible	

* Required information in the AzEIP database.

Child's Name | Date of Birth *(MM/DD/YYYY)* | I-TEAMS ID

SECONDARY INSURANCE TYPE* ***(If applicable)*** ◯ **Private** ◯ **HSA** ◯ **HRA** ◯ **Public**	
Insurance/Health Plan Name*	Plan Type *(EPO, PPO, HMO, etc.)*
Member's ID or AHCCCS ID*	Insurance Customer Service Phone Number
Policy Number *(If different than above)*	Member's Name *(as written and spelled on insurance card)*
Policyholder's Name *(If different than member name)*	Policyholder's Date of Birth
Policyholder's Employer *(If applicable for group coverage)*	Group Number*
Insurance Claims/Provider Phone Number	Claims Address
Coverage Start Date*	Coverage End Date *(Leave blank if unknown)*
Has the deductible for the year been met? ◯ Yes ◯ No ◯ Not sure ◯ No deductible	
TERTIARY INSURANCE TYPE* ***(If applicable)*** ◯ **Private** ◯ **HSA** ◯ **HRA** ◯ **Public** **Service Coordinator please contact AzEIP Help Desk for assistance entering a third insurance in to AzEIP database**	
Insurance/Health Plan Name*	Plan Type *(EPO, PPO, HMO, etc.)*
Member's ID or AHCCCS ID*	Insurance Customer Service Phone Number
Policy Number *(If different than above)*	Member's Name *(as written and spelled on insurance card)*
Policyholder's Name *(If different than member name)*	Policyholder's Date of Birth
Policyholder's Employer *(If applicable for group coverage)*	Group Number*
Insurance Claims/Provider Phone Number	Claims Address
Coverage Start Date*	Coverage End Date *(Leave blank if unknown)*
Has the deductible for the year been met? ◯ Yes ◯ No ◯ Not sure ◯ No deductible	

* Required information in the AzEIP database.

https://des.az.gov/services/developmental-disabilities/early-intervention/videos