Arizona Department of Economic Security
Arizona Early Intervention Program (AzEIP)

Health Insurance Agreement

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

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

Clinic Name _____ Clinic Address or Cross Streets _____

I agree the following information or support was provided:

- 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. I have received a(n) Select Method of the booklet per my request.
- My service coordinator reviewed with me the Child and Family Rights in the Arizona Early Intervention Program, GCI-1070A which describes my child and family rights with AzEIP. I have received a(n) Select Method of the booklet per my request.
- My Service Coordinator explained that if I agree 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 to use my health insurance for AzEIP services, my family's early intervention services will not be denied or delayed.
- My Service Coordinator explained how Early Intervention services are funded in Arizona with AzEIP partner agencies and has explained the benefits and impacts of using my insurance. I understand that not agreeing 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 using my insurance at any time. I understand that any change will apply only to services provided after I notify my SC of my decision.
- I will need to complete a new Health Insurance Agreement when there are changes to my decision, my insurance plan or coverage, or if there are service increases on my IFSP.
- I was offered a copy of this completed Health Insurance Agreement.

Parent/Guardian 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/Guardian Initials: _____

My selection below indicates that I voluntarily agree for AzEIP providers, contractors, and subcontractors to bill my selected insurance plan(s) to pay for covered early intervention services from the date of this agreement until it is revoked in writing or replaced with a new agreement.

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

Private Insurance: * Select Decision

Health Savings Account *(HSA)*: * Select Decision

Health Reimbursement Agreement *(HRA)*: * Select Decision

I understand that if my elected insurance plan automatically uses my HRA/HSA, it may be billed for AzEIP services.

See page 3 for EOE/ADA disclosures

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

If applicable, the reason I declined to use one or more of my insurance plans for one or more services *(completed by parent/guardian)*: _____

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

Parent/GuardianSignature: _____ Agreement Date* : _____

Primary Private Insurance Type* *(If applicable)*	
Insurance/Health Plan Name*	Plan Type *(EPO, PPO, HMO, etc.)*
Member's 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 Customer Service 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	Service / discipline exclusions for this insurance
Secondary Insurance Type* *(If applicable)* ○ **Private** ○ **HSA** ○ **HRA**	
Insurance/Health Plan Name*	Plan Type *(EPO, PPO, HMO, etc.)*
Member's 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 Customer Service 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	Service / discipline exclusions for this insurance

* Required information in the AzEIP database.

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

Tertiary Insurance Type* *(If applicable)* ◯ **Private** ◯ **HSA** ◯ **HRA** **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*	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 Customer Service 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	Service / discipline exclusions for this insurance

* Required information in the AzEIP database.

A Family's Guide to Funding Early Intervention Services in Arizona
des.az.gov/sites/default/files/legacy/dl/GCI-1086A.pdf