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) _____ PCP Phone Number (###) ###-#### _____

My Service Coordinator offered 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, and 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 Service Coordinator has explained how Early Intervention services are funded in Arizona with AzEIP partner agencies. My Service coordinator has also explained the benefits and impacts of using my insurance.
◯ Yes ◯ No

My selection below indicates that, I either voluntarily agree or decline for AzEIP, including its providers, contractors, and subcontractors, to bill my insurance plan(s) to pay for covered early intervention services. If I agree, I also consent to the release of any information necessary to file a claim with my health plan including sharing my personally identifying information and early intervention records with my health plan(s).

If I receive an Explanation of Benefits *(EOB)* or Notice of Action *(NOA)*, I understand that I have a responsibility to share a copy with my early intervention provider, if requested. If I receive payments from my insurance company for my provider, I have a responsibility to turn over the payment to my early intervention provider.

I have the right to change my mind about consenting to use my insurance at any time. I understand that if I change my consent in the future, this decision will not affect my family's early intervention services. This consent is valid for one year *(12 months)* from the consent date unless I revoke it before the end of that time, in writing or when I complete a new Consent to Bill Health Insurance, whichever happens first.

If I need specific information about my child's insurance coverage, I may need to contact my insurance's website or customer service phone number on the card.

My decision for each insurance type is listed below:

Private Insurance: ◯ I agree *(Yes)* ◯ I decline *(No)* ◯ My child does not have a private insurance plan.
Health Savings Account *(HSA)*: ◯ I agree *(Yes)* ◯ I decline *(No)* ◯ My child does not have an HSA.
Health Reimbursement Account *(HRA)*: ◯ I agree *(Yes)* ◯ I decline *(No)* ◯ My child does not have an HRA.
Public Insurance: ◯ I agree *(Yes)* ◯ I decline *(No)* ◯ My child does not have a public insurance plan.

The reason I decline to use one or more of my insurance plan:

☐ I would like help from my Service Coordinator to learn how to obtain health insurance.

Parent (IDEA Parent) Signature _____ Consent Date* _____

Service Coordinator Signature _____ Date _____

See page 3 for EOE/ADA disclosures

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

PRIMARY INSURANCE TYPE* ***(If applicable)*** ◯ **Private** ◯ **Public**	
Insurance/Health Plan Name*	Plan Type *(EPO, PPO, HMO, etc.)*
Member's ID or AHCCS 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's *(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	

SECONDARY INSURANCE TYPE* ***(If applicable)*** ◯ **Private** ◯ **HSA** ◯ **HRA** ◯ **Public**	
Insurance/Health Plan Name*	Plan Type *(EPO, PPO, HMO, etc.)*
Member's ID or AHCCS 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's *(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	

* 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** ○ **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 AHCCS 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's *(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	

* Required information in the AzEIP database.