

## Consent to Bill Insurance

<b>Child's Name:</b>	<b>Date of Birth:</b>
<b>Public Insurance and Tricare Information</b>	
<b>Medicaid or Denali KidCare #</b>	<b>TRICARE #</b>
	<b>TRICARE Subscriber Name:</b>
	<b>TRICARE Subscriber DOB:</b>
<b>Is this child eligible for Indian Health Benefits? (Circle One)      YES    NO</b>	
<b>Name and Phone of Primary Insurance:</b>	
<b>Policy #</b>	<b>Policy Holder Name:</b>
<b>Group #</b>	<b>Group Employer Name:</b>
<b>Branch Address (on back of card)</b>	
<b>Name and Phone of Secondary Insurance:</b>	
<b>Policy #</b>	<b>Policy Holder Name:</b>
<b>Group #</b>	<b>Group/Employer Name:</b>
<b>Branch address (on back of card)</b>	

**Consent to Bill Public and/or Private Insurance** I give my permission to the Infant Learning Program to bill my public benefit or insurance (e.g. Medicaid, Denali KidCare, TRICARE), and/or private insurance for the following: evaluations, assessments, and/or services listed in my child's IFSP. I authorize release of necessary medical information to process claims.

Although some services are at no cost to families, the State of Alaska's Infant Learning program is required to access all available funding sources for all other services. Families are required to identify other funding sources and are requested to allow the Infant Learning Program to bill those public and private sources for the services they receive. Families who decline to consent to bill the public and private insurance will continue to receive Infant Learning services. A *Consent to Bill Insurance* will be done prior to initial ILP enrollment, and at any time there is a change in services in the IFSP resulting in a cost change, or change in the family's insurance coverage.

I certify that the information provided on this form is true and correct and agree that I will notify my local ILP program of any changes. I have received a copy of the *Alaska Early Intervention/Infant Learning Billing Policy Summary*, and this information has been explained to me.

**Parent/Guardian Printed Name:** \_\_\_\_\_ **Date** \_\_\_\_\_

**I DO give permission** to bill the above insurance for Early Intervention services provided to my child.

**Parent/Guardian Signature** \_\_\_\_\_

**I DO NOT** give permission to bill the above insurance for Early Intervention services provided to my child.

**Parent Guardian Signature** \_\_\_\_\_

**I do not have health insurance at this time.**

**Parent/Guardian Signature** \_\_\_\_\_

**There are no changes to my insurance as of this date** \_\_\_\_\_ **Parent Signature** \_\_\_\_\_