BabyNet
South Carolina's Early Intervention System
SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Insurance Resources/ Consent to Bill

The BabyNet Program provides services to eligible children paid for by a combination of state and federal funds and reimbursement from private health insurance and Medicaid. In order for private insurance to be billed, parent must provide consent.

1. Child's Name:	Date of Birth:
2. ☐ Initial Completion Date:	☐ Review Date:

3. **Consent to bill insurance plan(s):**

☐ **I give permission for state agency and/or private providers of the BabyNet system of services to bill the insurance company (ies) listed below for covered services, and to exchange information necessary to secure payment for these services. (Such necessary information may include my child's diagnosis, service dates, types of services, and other information related to BabyNet system services needed to process claims.)**

☐ **I understand that if an insurance payment is made directly to me for BabyNet services, I am responsible for immediately sending such payments to the BabyNet provider who delivered the service.**

☐ **I will notify my BabyNet Service Coordinator of any changes to my child's health insurance or Medicaid coverage, including denial information.**

☐ **I do not give consent for BabyNet and/or private providers to bill my insurance company.**

Parent Signature: _____ **Date:** _____

4. **Primary Insurance**		5. **Secondary Insurance**	
Policy Holder Name:		Policy Holder Name:	
Relationship to Child:		Relationship to Child:	
Policy Holder's Address:		Policy Holder's Address:	
Insurance Company:		Insurance Company:	
Phone Number:		Phone Number:	
Claim Address:		Claim Address:	
Member Number:	Plan Name:	Member Number:	Plan Name:
Group Number:	Effective Date:	Group Number:	Effective Date:
Employer:		Employer:	
Address:		Address:	

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6. Medicaid
Federal Law requires that Medicaid be used for eligible children.

Child's Medicaid Number: _____

Check one: ☐ Medicaid Fee For Service ☐ Managed Care Organization (MCO) ☐ Medical Home Network ☐ TEFRA	Application in process: ☐ Medicaid Fee For Service ☐ Managed Care Organization (MCO) ☐ Medical Home Network ☐ TEFRA
Plan Eligibility Date: _____	Date of Application: _____

Plan Name: _____

Plan Address: _____

Plan Phone Number: _____

Parent Signature: _____ **Date:** _____

7. I verify that my child is **not** covered by private health insurance or Medicaid at this time.

Parent Signature: _____ **Date:** _____

8. **Service Coordinator Signature:** _____ **Agency:** _____	**Date:** _____

INSTRUCTIONS
BN004
Insurance/Resources Consent to Bill

A. Purpose

The purpose of this form is to obtain parent/guardian consent to utilize private insurance for payment of BabyNet services, to identify when Medicaid is a resource, and to obtain insurance or Medicaid information changes.

B. USES

This form is to be used by the intake service coordinator (or designee) during the intake process. The information on this form must be reviewed annually. A new form must be completed whenever there is a change in insurance or Medicaid coverage.

C. Instructions

1. Enter child's name and date of birth.
2. Check box by 'Initial Completion Date' or 'Review Date' and enter applicable date.
3. Consent to bill insurance plan (s):
   In order for the BabyNet system providers to bill insurance, the parent must provide consent to do so. Parents should be encouraged to consent to insurance billing in order to maximize use of BabyNet resources. BabyNet is obligated to use all available financial resources for coverage of services; however, private insurance will only be used with the written consent of the parent/guardian.
   Ensure that parent understands that should a payment be made directly to the parent for a BabyNet service, the parent is responsible for sending the payment to the BabyNet provider who delivered the service.
   Ensure that the parent understands that the BabyNet Service Coordinator must be notified immediately of any changes to the child's insurance or Medicaid coverage, including denial information.
   The parent/guardian must sign and date the form.
4. Primary Insurance:
   Enter the name and address of the primary insurance policy holder, and their relationship to the child.
   Enter the name, phone number and claims address for the insurance company.
   Enter the member number, plan name, group number and effective date of coverage.
   When applicable, enter the name of the policy holder's employee and address.
   Policy holder must sign and date.
5. Secondary Insurance:
   When secondary insurance is applicable, enter the same information as entered under number 4, Primary Insurance.
6. Medicaid:
   Ensure that the parent is aware that federal law requires that Medicaid be used as a funding source for children eligible for Medicaid.
   Enter the Child's Medicaid Number.
   Check the applicable Medicaid type and enter the Medicaid eligibility plan date.
   When a child does not have Medicaid, but the application is in process, check the applicable type and enter the date of the application.
   Enter the Medicaid plan name, address, and phone number.
   Parent must sign and date
7. When the child is not covered by private health insurance or Medicaid, parent must verify by signature and date.
8. Service Coordinator completing the form must sign and date the form and enter the name of the agency/program they are representing.