



The Division of Specialized Care for Children (DSCC) is required to obtain information about each payment source that may be responsible, in whole or in part, for payment of your child’s medical expenses.

Please read carefully and follow these directions in completing **both sides** of the *Health Insurance Information and Certification* form (05.08-1-2).

HEALTH INSURANCE INFORMATION (05.08-1)

- Section A Write name, birthdate and social security number of the child.
- Section B Provide the employment/health insurance data on the individual listed as the Policyholder. Enclose a copy of the health plan identification card, if possible.
- Section C Complete for All Kids/Medicaid information. Provide the All Kids/Medicaid plan type, case and recipient number and if possible enclose a copy of the All Kids/Medicaid identification card or eligibility letter.
- Section D Check if your child is covered by more than one (1) payment source. If your child is covered by more than one public or private health insurance source, complete a *Health Insurance Information* form (05.08-1-2) for each source. Please call the Regional Office serving your area and we will send you additional copies.
- Section E Check this box if the child is not covered by any health insurance.

HEALTH INSURANCE CERTIFICATION (05.08-2)

Signature on this form is required as follows:

- All Kids Rebate and All Other Health Insurance Coverage.....Parent/guardian must sign
- All Kids Assist, Share, Premium, All Kids Premium 2 – 8, Medicaid
Medicaid Managed Care/HMO, Medicaid Spend-down.....No signature required

A. Need Help With This Form?

For help in completing this form or any other DSCC application forms, contact the Regional Office serving your area. If you do not know which office is serving your area, you may contact DSCC toll free at 800-322-3722.



A. CHILD'S INFORMATION

Child's Name _____ DSCC Case # _____
Last First Middle
 Date of Birth _____ Social Security Number _____

B. EMPLOYMENT/HEALTH INSURANCE DATA

Name of Employee _____ Relationship to Child _____
 Name of Employer _____ Employer Telephone # _____
 Employer Address _____ City _____ State _____ Zip _____

MUST COMPLETE INFORMATION BELOW IF CHILD IS COVERED BY HEALTH INSURANCE

Name of Policyholder (Insured) _____ Policyholder Birthdate _____
 Insurance Identification Number _____ Policyholder Social Security # _____
 Name of Insurance Company/Plan _____
 Street _____ City _____
 State _____ Zip _____ Telephone # _____
 Policy/Group Number _____ Policy Effective Date _____

Policy Obtained By:
 Individual/Private Purchase
 Employer/Union/Group Purchase
 ICHIP (Illinois Comprehensive Health Insurance Plan)

Benefits Provided (indicate all that apply):
 Medical Vision
 Dental Pharmacy (Medication)

Type of Policy:
 Health Maintenance Organization (HMO) Exclusive Provider Organization (EPO)
 Point of Service (POS) COBRA (Consolidated Omnibus Reconciliation Act)
 Preferred Provider Organization (PPO) Discount
 Other _____

C. ALL KIDS/MEDICAID

Does Child Have?
 All Kids Assist Medicaid
 All Kids Share Medicaid Spend-down
 All Kids Premium Level 1
 All Kids Premium Level 2-8
 All Kids Rebate
 All Kids (Managed Care/HMO)
 Name of Managed Care/HMO Plan _____
 Address _____ Telephone # _____
 City _____ State _____ Zip _____

Case Name _____
 Case Number _____
 Recipient Number _____
 Program Effective Date _____

D. MULTIPLE POLICIES

Is your child covered by more than one policy? No Yes Total Number of Policies _____

E. NO HEALTH INSURANCE COVERAGE

The above named child is not covered by any health insurance policy.

(Over – Must Be Signed on Back)

Start Over

HEALTH INSURANCE CERTIFICATION FORM

I certify the information provided on this form is correct to the best of my knowledge. Falsification of this information can result in immediate loss of financial assistance provided by the Division of Specialized Care for Children (DSCC) and may result in legal action to recover any amounts paid by DSCC.

I will cooperate with DSCC in verifying any of the information provided on this document.

Child's Name _____ Birthdate _____

Name (print) _____ Relationship to Child _____

X Signature _____ Date _____

X Parent/guardian MUST sign

A PHOTOCOPY OF THIS DOCUMENT IS AS VALID AS THE ORIGINAL

Regional Office Use Only:

Regional Office _____ PCA _____ Date _____