



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 KidCare/Medicaid information. Provide the KidCare/Medicaid plan type, case and recipient number and if possible enclose a copy of the KidCare or 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:

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

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 Last First Middle DSCC Case #
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: Benefits Provided (indicate all that apply):
Type of Policy:

C. KIDCARE/MEDICAID

Does Child Have?
KidCare Assist Case Name
KidCare Share Case Number
KidCare Premium Recipient Number
KidCare Rebate Program Effective Date
Medicaid
Medicaid Spend-down
Medicaid (Managed Care/HMO)
Name of Managed Care/HMO Plan
Address
Telephone
City State Zip

D. MULTIPLE POLICIES

Is your child covered by more than one policy? No Yes How Many?

E. NO HEALTH INSURANCE COVERAGE

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

(Over - Must Be Signed on Back)

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 _____