
YOUR CHILD'S INSURANCE INFORMATION

Child's Name _____

Insurance Company _____

Address _____

Telephone (____) _____

Name of contact person _____

Insurance contact person at place of employment _____

Telephone (____) _____

Name of Employer _____

Address of Employer _____

Name of Insured _____ Policy Number _____ Group Number _____

Policy Effective Dates _____

Is this policy the _____ primary or _____ secondary policy for payment of your child's medical bills?

How much is your deductible? _____

How much is covered for the following services:

Doctor's Office Visits? _____

Doctor's Hospital Visits? _____

Emergency Room Care? _____

Hospitalizations? _____

Surgeries? _____

Outpatient Hospital Care? _____

Outpatient Hospital Care? _____

Durable Medical Equipment? _____

Orthotic/Prosthetic Devices? _____

Medical Supplies? _____

Prescribed Medications? _____

Home Care? _____

Skilled Nursing Care? _____

Therapy?

Speech _____

Occupational _____

Physical _____

Respiratory _____

Cardiac Rehabilitation _____

Other _____

Diagnostic Tests?

Laboratory _____

X-Ray _____

Other _____

Ambulance Services? _____

Dental Care? _____

Mental Health Services?

Inpatient _____

Outpatient _____

What services are excluded from coverage? _____

