Public & Private Insurance Form

CHILD INFORMATION		
First Name:	**MI:**	**Last Name:**
Child's SSN:		**DOB:**

New Mexico Medicaid pays for FIT Program services (The Department of Health pays the state match)

PUBLIC HEALTH INSURANCE INFORMATION (Including Medicaid / Medicare / Tricare)	
Name of public health plan:	**Id # / Member #:**

In accordance with New Mexico state statute, private health insurance plans must reimburance for FIT Program services up to $3,500 per year. The Department of Health pays for any services over $3,500. No co-pays or deductables are charged to families.

PRIVATE HEALTH INSURANCE INFORMATION		
Name of health insurance company:	**Health insurance company phone (see back of card):**	
Health Plan Address (see back of card for where to send claim):		
Street Address:		
City:	**State:**	**Zip code +4:**
Group Name/Plan Name (note may be name of employer):		**Eligibility Start Date:**
Group # (if applicable):	**Policy # / Member #:**	

PRIVATE HEALTH INSURANCE - POLICY HOLDER INFORMATION *(Please use another form if the child is covered under more than one policy)*		
First Name:	**MI**	**Last Name:**
Policy Holder's SSN:	**Employer:**	
Relationship to child (check one) ❑ **Father** ❑ **Mother** ❑ **Guardian** ❑ **Other (specify)**		
Policy Holder Street Address:		
City:	**State:**	**Zip code +4:**

If possible make copies of the front and back of the insurance card

If the child has neither Medicaid or private insurance coverage – use the Insurance Worksheet form to determine if they may be eligle for coverage.

To be completed by the parent(s) (Please check all that apply):

☐ I agree ☐ do not agree that the above information is correct as of this date and will inform the FIT provider agency of any changes.

☐ I agree ☐ do not agree for the NM FIT Program to bill our child's private and/or public health insurance (including Medicaid) for the early intervention services we receive and understand that we will not be charged a co-pay or deductable. I also understand that I may withdraw consent to disclose personally identifiable information to public insurance and private insurance for billing purposes.

Signature of Parent:	*Date:*
Signature of Parent:	*Date:*