## *CFC FAX COVER SHEET FOR INSURANCE REQUESTS*

| To: **Central Billing Office / Insurance Unit** | From (Name): |
|---|---|
| Fax Number Sent to: | CFC: |
| Date: | Senders Phone: |
| Child's Name: | Child's EI#: |
| Initial _____ Annual _____ | |

| Request Type(s) | Required Attachments |
|---|---|
| Insurance benefits check for :<br>PT____, ST____, OT:____ | - Enlarged insurance card copy _____<br>- Insurance affidavit _____ |
| Insurance benefits check for other service:<br>Type:________________________ | - Enlarged insurance card copy _____<br>- Insurance affidavit _____ |
| Assistive technology benefits check _____ | - Enlarged insurance card copy _____<br>- Insurance affidavit _____<br>- Copy of AT request cover page ____ |
| Pre-billing Waiver request<br>• Provider not available _____ | - List of insurance providers & contact information _____ **OR**<br>- Insurance website provider listing ___ **OR**<br>- Case note of conversation with insurance including contact person, date of contact, phone/e-mail _____ **AND**<br>- Date service could begin by insurance provider ____ |
| Pre-billing Waiver request<br>• Provider not enrolled _____ | - List of insurance providers & contact information _____ **OR**<br>- Insurance website provider listing _____ **OR**<br>- Case note of conversation with insurance including contact person, date of contact, phone/e-mail _____ |
| Pre-billing Waiver request<br>NOTE: This waiver type is <u>not applicable for onsite services</u><br>• Travel time/distance _____ | - List of insurance providers including address & contact information _____ **AND**<br>- Name, address and contact info. of EI enrolled /credentialed provider waiver requested for **AND**<br>- Family's primary mode of transportation _____ **AND**<br>- Address the family is traveling from ____ |
| Exemption request<br>• Individual plan _____ | - Written documentation from insurance company stating plan not privately purchased and not part of a group _____ |
| Exemption request<br>○ ICHIP _____ | - Copy of insurance card (ICHIP only)_____ |
| Exemption request<br>• Lifetime cap _____ | - Written documentation from insurance stating amount of cap _____**OR**<br>- Written documentation from insurance showing remaining amount of cap_____ **AND**<br>- Cornerstone authorizations _____ |
| Responding to CBO request | - Other _____ |

*IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.* *(06/07)*