CHILD AND FAMILY CONNECTIONS
FAX COVER SHEET FOR INSURANCE BENEFITS VERIFICATION REQUESTS/UPDATES

Section 1: Complete this section completely		
To: Central Billing Office / COB Unit	From (Name):	
Fax Number Sent to: 1-217-492-5602	CFC #:	Total Pages including cover:
Date:	Senders Phone:	
Child's Name:	Child's EI#:	Insurance Plan Owner's Name:
Primary Care Physician Name:	Primary Care Physician Phone # :	

Section 2: Benefits Verification Request	Required Attachments
Insurance benefits check for (check only applicable services): ☐ PT ☐ PT Group ☐ ST ☐ ST Group ☐ OT ☐ OT Group ☐ SW ☐ SW Group ☐ NU ☐ NU Group ☐ Psych ☐ Psych Group ☐ AU/AR	- Enlarged insurance card copy (front and back) ☐ - *Consent to Use Private Insurance/Healthcare Plan Benefits & Assignment of Rights* ☐
Location Required for all services identified above. Choose appropriate location for each or all services as indicated under *Required Attachments*.	☐ All Offsite ☐ All Onsite ☐ Other (specify) _____ Partial Offsite (check services) ☐ PT ☐ ST ☐ OT ☐ Other (specify) _____ Partial Onsite (check services) ☐ PT ☐ ST ☐ OT ☐ Other (specify) _____
Assistive technology benefits check ☐	- Enlarged insurance card copy ☐ - *Consent to Use Private Insurance/Healthcare Plan Benefits & Assignment of Rights* ☐ - Copy of *AT request* cover page ☐
Annual Meeting Date: Only needed if submitting request for annual more than 30 days prior to IFSP end date showing in Cornerstone	

Section 3: Change/Update to current IFSP insurance information (not for Initial / Annual)	Required Attachments
Existing Insurance Ended ☐	Date insurance reportedly ended: _____ AND Any letters from insurance company, if available.
New/Different Insurance Obtained ☐	Complete Sections 1 and 2 and include copy of card (front and back) and *Consent to Use Private Insurance/Healthcare Plan Benefits & Assignment of Rights.* If no card is available, complete the *CFC Change of Insurance Notification* form and submit along with this request.
CFC TRANSFER INFORMATION: Receiving CFC must submit new BV request if changing providers.	Receiving CFC #: _____ Sending CFC #: _____

Section 4: Waiver / Exemption Request	Required Attachments
Pre-billing Waiver request • Provider not available ☐	- Case note of conversation with Payee/Provider(contact person, date of contact, phone/email) - Pre-Billing Insurance Wavier Request form completed
Pre-billing Waiver request (if not discovered and approved during initial BV): • Provider not enrolled ☐	- Case note of conversation with Payee/Provider (contact person, date of contact, phone/email) - *Pre-Billing Insurance Wavier Request* form completed
Pre-billing Waiver request NOTE: This waiver type is not applicable for offsite services • Travel time/distance ☐	- Family's primary mode of transportation _____ AND - Address the family is traveling from _____ - *Pre-Billing Insurance Wavier Request* form completed
Exemption request (If not automatically discovered and exempted during initial BV): • Individual purchased/ non-group plan ☐	- Written documentation from insurance company stating plan is privately purchased and not part of a group ☐
Exemption request • Annual or Lifetime cap ☐	- Written documentation from insurance stating amount of annual/ lifetime cap ☐ OR - Written documentation from insurance showing remaining amount of annual/lifetime cap ☐ AND - Cornerstone authorizations ☐
Exemption request • Automatically withdrawing Tax Savings Plan ☐	- Completed CFC Tax Savings Account Information Sheet ☐
New Payee Waiver request (not due to change of insurance): • Change of Provider ☐ (new Payee only)	- Case note indicating reason for change. - Complete Section 2 and follow procedures to maximize insurance.
Responding to CBO request	- Other ☐