

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): <input type="checkbox"/> PT <input type="checkbox"/> PT Group <input type="checkbox"/> ST <input type="checkbox"/> ST Group <input type="checkbox"/> OT <input type="checkbox"/> OT Group <input type="checkbox"/> SW <input type="checkbox"/> SW Group <input type="checkbox"/> NU <input type="checkbox"/> NU Group <input type="checkbox"/> Psych <input type="checkbox"/> Psych Group <input type="checkbox"/> AU/AR	- Enlarged insurance card copy (front and back) <input type="checkbox"/> - <i>Consent to Use Private Insurance/Healthcare Plan Benefits & Assignment of Rights</i> <input type="checkbox"/>
Location Required for all services identified above. Choose appropriate location for each or all services as indicated under <i>Required Attachments</i> .	<input type="checkbox"/> All Offsite <input type="checkbox"/> All Onsite <input type="checkbox"/> Other (specify) _____ Partial Offsite (check services) <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify) _____ Partial Onsite (check services) <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify) _____
Assistive technology benefits check <input type="checkbox"/>	- Enlarged insurance card copy <input type="checkbox"/> - <i>Consent to Use Private Insurance/Healthcare Plan Benefits & Assignment of Rights</i> <input type="checkbox"/> - Copy of <i>AT request cover page</i> <input type="checkbox"/>
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 <input type="checkbox"/>	Date insurance reportedly ended: _____ AND Any letters from insurance company, if available.
New/Different Insurance Obtained <input type="checkbox"/>	Complete Sections 1 and 2 and include copy of card (front and back) and <i>Consent to Use Private Insurance/Healthcare Plan Benefits & Assignment of Rights</i> . If no card is available, complete the <i>CFC Change of Insurance Notification</i> 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
<i>Pre-billing Waiver request</i> • Provider not available <input type="checkbox"/>	- Case note of conversation with Payee/Provider(contact person, date of contact, phone/email) - Pre-Billing Insurance Wavier Request form completed
<i>Pre-billing Waiver request</i> (if not discovered and approved during initial BV): • Provider not enrolled <input type="checkbox"/>	- Case note of conversation with Payee/Provider (contact person, date of contact, phone/email) - <i>Pre-Billing Insurance Wavier Request</i> form completed
<i>Pre-billing Waiver request</i> NOTE: This waiver type is <u>not applicable for offsite services</u> • Travel time/distance <input type="checkbox"/>	- Family's primary mode of transportation _____ AND - Address the family is traveling from _____ - <i>Pre-Billing Insurance Wavier Request</i> form completed
Exemption request (If not automatically discovered and exempted during initial BV): • Individual purchased/ non-group plan <input type="checkbox"/>	- Written documentation from insurance company stating plan is privately purchased and not part of a group <input type="checkbox"/>
Exemption request • Annual or Lifetime cap <input type="checkbox"/>	- Written documentation from insurance stating amount of annual/ lifetime cap <input type="checkbox"/> OR - Written documentation from insurance showing remaining amount of annual/lifetime cap <input type="checkbox"/> AND - Cornerstone authorizations <input type="checkbox"/>
Exemption request • Automatically withdrawing Tax Savings Plan <input type="checkbox"/>	- Completed CFC Tax Savings Account Information Sheet <input type="checkbox"/>
New Payee Waiver request (not due to change of insurance): • Change of Provider <input type="checkbox"/> (new Payee only)	- Case note indicating reason for change. - Complete Section 2 and follow procedures to maximize insurance.
Responding to CBO request	- Other <input type="checkbox"/>

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.