

**Insurance Information Form**

If not completed in its entirety, reimbursement may be delayed

The following information is needed for review of your request for IRC assistance with insurance copayments, coinsurance or deductible for your child. **Completion and return is due by December 31, 2017, Attn: Julie Brown, Behavior Specialist Technician.**

IRC will be able to proceed with the review of your continued request when all the below information has been received.

**Client and Insurance Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_ UCI#: \_\_\_\_\_\_\_\_\_\_\_\_

Number of children in family who are regional center clients: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of family members in your household: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed: Mother [ ] Yes [ ] No Father [ ] Yes [ ] No

Private Insurance Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: [ ]HMO [ ] PPO [ ] POS

Medi-Cal: [ ] Yes [ ] No if yes, BIC#: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**PLEASE CONTACT YOUR INSURANCE COMPANY or HUMAN RESOURCES DEPARTMENT FOR THE FOLLOWING INFORMATION (you may also submit a copy of the Coverage Book to** [jbrown@inlandrc.org](mailto:jbrown@inlandrc.org)**) :**

Annual Maximum Out-of-Pocket:

Individual $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Out-of-Pocket: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if more than RC consumer)

Co-payment Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per day

Deductible Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if applicable to the service

Deductible met? [ ] No [ ] Yes, date: \_\_\_\_\_\_\_\_\_\_\_\_

Plan Year Begins**[[1]](#footnote-1):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Month)

**Services for which you are requesting assistance: (Services must be related to the developmental disability/developmental delay; agreed to by the planning team; and included in the client’s IPP)**

Type of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Provider: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In-network provider? [ ] Yes [ ] No

Frequency of Service: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please read the following information carefully:**

* I agree to sign Authorization for Use or Disclosure of Information forms for IRC to obtain information from my insurance company and the provider(s) of developmental health treatment services.
* I understand that I must meet the financial requirements for IRC to fund my copayment, coinsurance or deductible for developmental health treatment services.
* I understand that if I do not meet financial eligibility requirements, funding of my copayment, coinsurance or deductible may be considered if I am able to demonstrate an extraordinary event, a catastrophic loss or significant unreimbursed medical costs. I understand that I must provide necessary information which verifies any financial need.
* I understand that my service provider must be a regional center vendor.
* I understand that IRC funding my copayment, coinsurance or deductible will be at the **in-network rate**.
* I understand that the services for which I am requesting copayment, coinsurance or deductible reimbursement must be on my child’s IPP.
* I understand that my signature below authorizes IRC to make my required copayment, coinsurance or deductible directly to the service provider.

**Please return this form, signed, along with the following:**

* A copy of the insurance card for the client (front and back)
* Insurance Coverage Benefits Summary
* Signed Authorization for Use or Disclosure of Information forms; one form completed for your insurance company and form(s) completed for your provider(s).

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Insured Date

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_

Print Name

Return forms in the enclosed envelope to:

Inland Regional Center

P.O. Box 19037

San Bernardino, CA 92423-9037

1. [↑](#footnote-ref-1)