

tiny-k Early Intervention

Reimbursement Information

Child's Name: _____ Child's Social Security Number: _____

Parent/Guardian's Names: _____

Primary Care Physician: _____

Diagnosis: Developmental Delay

Intended Payment Method: (please check one)

_____ Please bill Medicaid for all Part C Early Intervention Services

Medicaid Information

· Type of Medicaid Plan: _____

· Number: _____

· Name as it appears on child's card: _____

_____ Any service provided by tiny-k Early Intervention contracted agency will be billed to my insurance or Medicaid as appropriate. The tiny-k Early Intervention will pay any co-payments or deductibles related to those services.

Insurance Information

· Name of Company or Agency: _____

· Address: _____ · Claims Phone Number: _____

· Name of Insured: _____

(as it appears on the insurance card)

· Individual ID Number: _____ · Group Number: _____

_____ tiny-k Early Intervention will pay for all Part C Early Intervention Services

My financial rights and responsibilities as the parent/guardian of a child between the ages of birth to three years have been explained to me.

Signature

Date