Children's Integrated Services
Permission to Bill Public and Private Insurance

Date

Client Name: Client Date of Birth

Client Social Security Number: Client Medicaid UID:

Consent to Bill Insurance

- ☐ I understand that I may refuse to give this consent, and this refusal will not affect any benefits for which my child and family are entitled.
- ☐ I understand that by giving permission to seek payment from my insurance, information about me/my child's CIS services may be shared in this process.
- ☐ I understand that I may revoke consent to bill my private insurance at any time. If I revoke this consent it will apply to billing for services from that date forward. I can revoke my consent by writing to the address below.
- ☐ I understand I will be informed about Early Intervention financial support, if this is a service my child is entitled to in the system of payments brochure.
- ☐ **I acknowledge that Children's Integrated Services will bill my Medicaid insurance for services provided to me/my child.**

Early Intervention & Strong Families Vermont Family Support Home Visiting (Parents as Teachers) Only: Private Insurance Information

- ☐ **I give my permission for Children's Integrated Services to bill my private Insurance for services provided to me/my child.**

Name of Insurance Company: Policy Number:

Group or Contract Number: Policy Effective Date:

Employer or Group Name: Policy Holder Name:

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CHILD DEVELOPMENT DIVISION

☐ **I decline permission for Children's Integrated Services to bill my private insurance for services provided to me/my child**.

If declining permission to bill private insurance, please provide the reason:

☐ My available Health Savings Account (HAS) would be depleted

☐ My other health insurance benefits would decrease

☐ My health insurance premiums would increase

☐ I risk loss of eligibility for me/my child for home and community waivers

☐ My private insurance doesn't cover Strong Families Vermont Family Support Home Visiting (Parents as Teachers)

I certify the information I have provided on this form is correct and agree that I will notify DCF/CDD of any changes to this information. Changes should be mailed to: Vermont DCF Child Development Division – Children's Integrated Services, 280 State Drive, NOB 1, Waterbury, VT 05671-2090

Client, or Parent/Guardian Signature:

Date:

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