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

Date: _____

Child's Name: _____

Child's Social Security Number: _____

Child's Date of Birth: _____

Office Use Only
CIS-02 Supplemental with Family
Version 3.21
Ins. Co #: _____ (office use only)

Primary Insurance Information

Name of Insurance Company: _____ Insurance Company Phone: _____

Insurance Company Address: _____

Policy Number: _____ Group or Contract Number: _____ Policy Effective Date: _____

Employer or Group Name: _____ Policy Holder Name: _____

Consent to Bill Insurance

- I give my permission to AHS Children's Integrated Services (CIS) to bill my private or public insurance for the specified services listed in my/my child's One Plan.
- I understand that I may refuse to give this consent.
- I understand, if my child qualifies for Part C Early Intervention program services and I refuse consent to bill my private or public insurance for One Plan services this refusal will not affect services for my child that are covered by the Part C Early Intervention Program.
- I understand that by giving permission to seek payment from my insurance, information about me/my child's CIS may be shared in this process.
- I understand that if I choose not to sign this form, any benefits for which my child and family are entitled will not be affected.
- I understand that I may revoke consent to bill my private or public 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 give my permission for Children's Integrated Services to bill: ☐ Private Insurance ☐ Medicaid

For services provided to me or my child for CIS One Plan services or Part C Early Intervention services. I understand that information about my/my child's services including early intervention services may be shared in that process.

OR

☐ I decline permission for Children's Integrated Services, including Part C Early Intervention, 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 would be depleted.

☐ My health insurance premiums would increase

☐ My other health insurance benefits would decrease.

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

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:_____

VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION