Reset Form

INDIANA FIRST STEPS INSURANCE INFORMATION AND CONSENT

State Form 51308 (R7 / 2-21)
FAMILY AND SOCIAL SERVICES ADMINISTRATION

INSTRUCTIONS:
1. *Sections 1 and 2 of this form must be completed for all families with public or private health insurance.*
2. *Section 3 of this form must be completed if consent is given to bill insurance.*
3. *A copy of the insurance card(s) must also be uploaded displaying both the front and back sides of the card(s).*

SECTION 1 - CHILD INFORMATION

Name of child		Name(s) of parent(s)	
Today's date *(month, day, year)*	First Steps identification number	Date of birth *(month, day, year)*	Date of referral *(month, day, year)*
Name of service coordinator	Single Point of Entry (SPOE)	County	

SECTION 2 - CONSENT TO BILL INSURANCE

Indiana First Steps uses several different funding sources to pay for services. Public and private health insurance are two of these sources. Other sources include family cost participation, federal funding, and state funding.

First Steps is required to obtain your consent before billing your health insurance. First Steps is also required to obtain your consent before communicating with your insurance on issues related to claims payment.

Your consent applies to all services on your individualized family service plan (IFSP). First Steps will make a good faith effort to collect payment from health insurance, but payment is not guaranteed.

You can revoke your consent in writing at any time. **Consent or revoked consent will not be retroactive.**

☐ I consent to First Steps billing my health insurance and communicating with my insurance on issues related to claims payment. I understand First Steps will make a good faith effort to collect payment from my health insurance, but that **payment is not guaranteed.** I understand my family cost participation is waived only if my health insurance pays. If my insurance does not pay, I understand I will be responsible for my First Steps cost participation as applicable.

☐ I **do not** consent to First Steps billing my insurance. **I understand I will be responsible for all applicable First Steps cost participation fees.** *The maximum amount you may owe in cost participation depends on your copayment amount and the services on your IFSP. Please refer to your Cost Participation Worksheet/Copay Determination and talk to your service coordinator for more information.*

☐ **My service coordinator has explained my family's right to confidentiality under Part C of the Individuals with Disabilities Education Act (IDEA).** I understand if I believe my rights have been violated, I should e-mail FirstStepsWeb@fssa.in.gov, call 800-545-7763, or send my complaint via mail to 402 West Washington Street, room W453, Indianapolis, Indiana 46204.

Signature of parent	Date *(month, day, year)*
Printed name of parent	

SECTION 3 - INSURANCE INFORMATION

For assistance determining insurance plan type, please refer to the determination guidance.

Primary Insurance

Medicaid? ☐ Yes ☐ No	Name of primary insurance carrier	Name of policy holder
Policy holder date of birth *(month, day, year)*	Policy / member identification number or Medicaid RID	Effective dates – From *(month, day, year)* To *(month, day, year)*
Group name	Group number	Health savings/spending account (HSA, HRA, FSA, etc.)? ☐ Yes ☐ No
Provider services telephone number *(back of card)* ( )	Name of employer	Employer out of state? ☐ Yes ☐ No
Policy holder relationship to child: ☐ Mother ☐ Father ☐ Step-parent ☐ Foster parent ☐ Other	Type of plan ☐ Self-insured ("ERISA") ☐ Fully Insured ("non-ERISA") ☐ State self-insured ("non-ERISA") (i.e. "exceptions")	

Secondary Insurance

Medicaid? ☐ Yes ☐ No	Name of secondary insurance carrier	Name of policy holder
Policy holder date of birth *(month, day, year)*	Policy / member identification number or Medicaid RID	Effective dates – From *(month, day, year)* To *(month, day, year)*
Group name	Group number	Health savings/spending account (HSA, HRA, FSA, etc.)? ☐ Yes ☐ No
Provider services telephone number *(back of card)* ( )	Name of employer	Employer out of state? ☐ Yes ☐ No
Policy holder relationship to child: ☐ Mother ☐ Father ☐ Step-parent ☐ Foster parent ☐ Other	Type of plan ☐ Self-insured ("ERISA") ☐ Fully Insured ("non-ERISA") ☐ State self-insured ("non-ERISA") (i.e. "exceptions")	

Tertiary Insurance

Medicaid? ☐ Yes ☐ No	Name of tertiary insurance carrier	Name of policy holder
Policy holder date of birth *(month, day, year)*	Policy / member identification number or Medicaid RID	Effective dates – From *(month, day, year)* To *(month, day, year)*
Group name	Group number	Health savings/spending account (HSA, HRA, FSA, etc.)? ☐ Yes ☐ No
Provider services telephone number *(back of card)* ( )	Name of employer	Employer out of state? ☐ Yes ☐ No
Policy holder relationship to child: ☐ Mother ☐ Father ☐ Step-parent ☐ Foster parent ☐ Other	Type of plan ☐ Self-insured ("ERISA") ☐ Fully Insured ("non-ERISA") ☐ State self-insured ("non-ERISA") (i.e. "exceptions")	