Rhode Island Department of Human Services

Long Term Services & Supports | Katie Beckett

P.O Box 8709 Cranston, RI 02920 | Phone: (401) 574-8474 | Fax: (401) 574-9915

KATIE BECKETT HEALTH INSURANCE REPORTING FORM

Please provide copies (front and back) of all health insurance cards. If you do not have health insurance, please write N/A and return this form with the clinical packet. If you have previously reported commercial insurance and that insurance has changed, please contact the Third-Party Liability team at 401-462-2181.

Child's Name: ______________________________ Child's DOB:_____________________ Child's SSN: _________________

Parent or Guardian Name: ___________________________________ Phone Number: _________________

MEDICAL INSURANCE

INSURANCE COMPANY: _______________________________________ PHONE: _____________________________

POLICY ID NUMBER: ____ GROUP ID: ___________________________

SUBSCRIBER NAME:: ______________________________ RELATIONSHIP TO CHILD: _______________________

SUBSCRIBER SSN: __________________________________ (To be provided if child is approved.)

EMPLOYER: ____

DENTAL INSURANCE

INSURANCE COMPANY: _______________________________________ PHONE: _____________________________

POLICY ID NUMBER: ____ GROUP ID: ___________________________

SUBSCRIBER: ______________________________________ RELATIONSHIP TO CHILD: _______________________

SUBSCRIBER SSN: __________________________________ (To be provided if child is approved.)

SEPARATE VISION SERVICE PLAN (VSP)

INSURANCE COMPANY: _______________________________________ PHONE: _____________________________

POLICY ID NUMBER: ____ GROUP ID: ___________________________

SUBSCRIBER: ______________________________________ RELATIONSHIP TO CHILD: _______________________

SUBSCRIBER SSN: __________________________________ (To be provided if child is approved.)

SEPARATE PRESCRIPTION COVERAGE

INSURANCE COMPANY: _______________________________________ PHONE: _____________________________

POLICY ID NUMBER: ____ GROUP ID: ___________________________

SUBSCRIBER: ______________________________________ RELATIONSHIP TO CHILD: _______________________

SUBSCRIBER SSN: ___________________________________ (To be provided if child is approved.)

Completed by: ____ Date: _________________________

DHS Katie Beckett Health Insurance Reporting Form (Cont.)

Please complete below if your child has double commercial coverage.

MEDICAL INSURANCE
INSURANCE COMPANY: ________________________________ PHONE: ________________________
POLICY ID NUMBER: __________________________________ GROUP ID: ______________________
SUBSCRIBER NAME:: _________________________ RELATIONSHIP TO CHILD: ___________________
SUBSCRIBER SSN: ___________________________ (To be provided if child is approved.)
EMPLOYER: ____
DENTAL INSURANCE
INSURANCE COMPANY: ________________________________ PHONE: ________________________
POLICY ID NUMBER: __________________________________ GROUP ID: ______________________
SUBSCRIBER: ______________________________ RELATIONSHIP TO CHILD: ___________________
SUBSCRIBER SSN: ___________________________ (To be provided if child is approved.)
SEPARATE VISION SERVICE PLAN (VSP)
INSURANCE COMPANY: ________________________________ PHONE: ________________________
POLICY ID NUMBER: __________________________________ GROUP ID: ______________________
SUBSCRIBER: ______________________________ RELATIONSHIP TO CHILD: ___________________
SUBSCRIBER SSN: ___________________________ (To be provided if child is approved.)
SEPARATE PRESCRIPTION COVERAGE
INSURANCE COMPANY: ________________________________ PHONE: ________________________
POLICY ID NUMBER: __________________________________ GROUP ID: ______________________
SUBSCRIBER: ______________________________ RELATIONSHIP TO CHILD: ___________________
SUBSCRIBER SSN: ___________________________ (To be provided if child is approved.)