MONTANA MILESTONES PART C INFORMED CONSENT FOR THE USE OF INSURANCE

Child's Name: _____Date of Birth: _____

Insurance Information
Medicaid ID: _____

Primary Insurance Company: _____
Policy Holder: _____ Policy Number: _____

Secondary Insurance Company: _____
Policy Holder: _____ Policy Number: _____

Acknowledgements of Supporting Documents
For each of the items below, my initials reflect that I have received a copy of the document and it has been explained to me.

(Parent's Initials):

_____ **Montana Milestones Part C Written Notification for the Use of Private Insurance and Public Benefits.**

_____ **Montana Milestones Part C System of Payments Policy.**

_____ **Montana Milestones Dispute Resolution Handbook with Procedural Safeguards.**

I received a copy of each the documents listed above, and they have been explained to me. I do not need an additional copy and I know I can access them any time at: https://dphhs.mt.gov/ecfsd/childcare/montanamilestones/part-c-early-intervention-guidance-and-forms

_____ (Parent's Initial)

No Insurance
(Parent Initials)

_____ My child does not have private or public insurance. I understand that I am not required to enroll my child in public benefits or insurance programs as a condition of receiving Montana Milestones as explained in the Montana Milestones System of Payments Policy.

Consent to Use Private Insurance

(Parent Initials)

_____ I provide consent to bill my private insurance for early intervention services listed on our IFSP. I authorize the release of personally identifiable information to my private insurance to request payment of benefits. I authorize my private insurance to make payments to my provider. I understand that I may revoke this permission at any time by notifying my Family Support Specialist. I understand if my child is covered by both Medicaid (public benefit) and private insurance, then my private insurance must be billed first. If insurance is billed and payment is made to my family rather than directly to my provider, I understand I must send the payment and Explanation of Benefits form to my provider.

_____ I do not provide consent to bill private insurance for early intervention services listed on our IFSP. I understand my child will be able to receive IFSP services even if I do not provide consent.

Consent to Use Public Insurance

_____ I provide consent to bill Medicaid or other public insurance for early intervention services listed on our IFSP. I authorize the release of personally identifiable information to Medicaid or other public insurance to request payment of benefits. I authorize Medicaid or my other public insurance to make payments to my provider. I understand that I may revoke this permission at any time by notifying my Family Support Specialist. I understand if my child is covered by both Medicaid (public benefit) and private insurance, then my private insurance must be billed first. If insurance is billed and payment is made to my family rather than directly to my provider, I understand I must send the payment and Explanation of Benefits form to my provider.

_____ I do not provide consent to bill Medicaid or my other public insurance for early intervention services listed on our IFSP. I understand my child will be able to receive IFSP services even if I do not provide consent.

Signature of Parent or Guardian _____ Date _____

Printed Name _____

Signature of Witness _____ Date _____

Printed Name _____