CALIFORNIA CHILDREN'S SERVICES
HEALTH INSURANCE INFORMATION

❒ Medical Insurance
❒ Dental Insurance

Patient's name	CCS number	County

Type of insurance plan (check one)

❒ Major medical ❒ Preferred Provider Organization (PPO) ❒ Health Maintenance Organization (HMO)

1. Name of insurance plan | Policy identification/group number | Effective date of policy

Claims office address (number, street) | City | State | ZIP code | Phone number ( )

2. Policy holder's name | Social security number

Address (number, street) | City | State | ZIP code

3. Employer of insured | Phone number ( )

Address (number, street) | City | State | ZIP code

4. Union name | Local number

Address (number, street) | City | State | ZIP code

DESCRIPTION OF INSURANCE BENEFITS

Child's Professional Care (Maximum Amount)

	Coverage Yes	Coverage No	Extent
5. Office visits	❒	❒	$
6. Outpatient, x-ray, laboratory	❒	❒	$
7. Surgery	❒	❒	$
8. Assistant surgery	❒	❒	$
9. Anesthesia	❒	❒	$
10. Hospital visits	❒	❒	$
11. Other	❒	❒	$
12. Limitations:			

Child's Hospital Care (Maximum Amount)

13. Room and board ☐ Yes ☐ No
$_____ per day for _____ days

14. Miscellaneous hospital services $

15. Limitations:

16. Major medical or extended benefits ☐ Yes ☐ No

	Yes	No		Yes	No		Yes	No
Prescriptions	❒	❒	Brace repairs	❒	❒	Dental plan	❒	❒
Glasses/repair	❒	❒	Hearing aids	❒	❒	Orthodontics	❒	❒
Braces	❒	❒	Hearing aid accessories	❒	❒	Other:	❒	❒

17. Deductible $_____ at _____% per ☐ Calendar year ☐ Benefit year
If benefit year, effective date _____ If newborn, effective date of policy

18. Maximum benefits $_____ per Lifetime of policy: ☐ Illness ☐ Year

19. I agree to repay California Children's Services any insurance proceeds improperly diverted by me. I acknowledge the Privacy Statement on the back side of this form.

Signature of parent or legal guardian	Date

Report completed by	Title	Date

PRIVACY STATEMENT

The information on this form is required by the county and state California Children's Services (CCS) as part of your application for assistance, as CCS cannot pay for that portion of expenses which are a benefit of your insurance resource. The information is maintained pursuant to Section 123800, *et seq*., of the California Health and Safety Code. You are required to provide the information on this form. If you do not provide this information, eligibility for services may be denied. Any information which you provide may be used by county and state CCS offices, the California Department of Health Care Services, and providers of services. You have a right to review records maintained by CCS concerning you. If you wish to review these records, contact the person responsible for the records in your county CCS office. Appeals may be directed to: Branch Chief, Children's Medical Services (CMS) Branch, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413 (telephone (916) 327-1400). After reviewing your records you may request in writing that they be corrected or amended to make them accurate, relevent, and complete.