

CALIFORNIA CHILDREN'S SERVICES HEALTH INSURANCE INFORMATION

Medical Insurance
 Dental Insurance

Patient's name	CCS number	County
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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)			Child's Hospital Care (Maximum Amount)			
	Coverage		Extent			
	Yes	No				
5. Office visits	<input type="checkbox"/>	<input type="checkbox"/>	\$	13. Room and board	Yes	No
6. Outpatient, x-ray, laboratory	<input type="checkbox"/>	<input type="checkbox"/>	\$	\$ _____ per day for _____ days		
7. Surgery	<input type="checkbox"/>	<input type="checkbox"/>	\$	14. Miscellaneous hospital services	\$	
8. Assistant surgery	<input type="checkbox"/>	<input type="checkbox"/>	\$	15. Limitations:		
9. Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	\$			
10. Hospital visits	<input type="checkbox"/>	<input type="checkbox"/>	\$			
11. Other	<input type="checkbox"/>	<input type="checkbox"/>	\$			
12. Limitations:						

16. Major medical or extended benefits		Yes	No			Yes	No	
Prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	Brace repairs	<input type="checkbox"/>	<input type="checkbox"/>	Dental plan	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/repair	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aids	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontics	<input type="checkbox"/>	<input type="checkbox"/>
Braces	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid accessories	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

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
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Report completed by	Title	Date
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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, relevant, and complete.