Medical Insurance Information

TIP: Include copies of all insurance cards, print and store in your C.A.R.E. Binder. Make sure you update this information each year when your policies renew.

Insurance Coverage
Does your loved one with rare epilepsy have any of the following:

Private Insurance ☐YES ☐NO

If yes, Policy Name:

Member ID Number:

Group Number:

Claims Address:

City: State: Zip:

Customer Service Phone:

Subscriber Name (Policy Holder):

Subscriber (Policy Holder) Date of Birth:

Online access, if applicable: Site link:

Username: Passcode:

Secondary Insurance (such as Tricare, if military, or other) ☐YES ☐NO

If yes, Policy Name:

Member ID Number:

Group Number:

Claims Address:

City: State: Zip:

Customer Service Phone:

Subscriber Name (Policy Holder):

Subscriber (Policy Holder) Date of Birth:

Medicaid ☐YES ☐NO

If yes, Policy Name:

Member ID Number:

Group Number:

Claims Address:

City: State: Zip:

Customer Service Phone:

Subscriber Name (Policy Holder):

Subscriber (Policy Holder) Date of Birth:

Case/Social Worker/Coordinator Name:

Medicare ☐ YES ☐ NO

If yes, Policy name:

Member ID Number:

Group Number:

Claims Address:

City: State: Zip:

Customer Service Phone:

Subscriber Name (Policy Holder):

Subscriber (Policy Holder) Date of Birth:

TIP: Visit Medicare for additional information on how to lower your Medicare prescription costs.

Part D Coverage ☐ YES ☐ NO

If yes, Policy name:

Member ID Number:

Group Number:

Claims Address:

City: State: Zip:

Customer Service Phone:

Subscriber Name (Policy Holder):

Subscriber (Policy Holder) Date of Birth:

Dental ☐ YES ☐ NO ☐ Covered under another policy

If yes, Policy name:

Member ID Number:

Group Number:

Claims Address:

City: State: Zip:

Customer Service Phone:

Subscriber Name (Policy Holder):

Subscriber (Policy Holder) Date of Birth:

Vision ☐ YES ☐ NO ☐ Covered under another policy

If yes, Policy Name:

Member ID Number:

Group Number:

Claims Address:

City: State: Zip:

Vision *(continued)*

Customer Service Phone:

Subscriber Name (Policy Holder):

Subscriber (Policy Holder) Date of Birth:

Waivers

Is additional insurance provided by a Deeming Waiver (Katie Beckett or other)? ☐ YES ☐ NO

If YES, summarize the renewal process below, including as much information as possible about this process.
(You can also attach separately to C.A.R.E. Binder.)

Is your loved one accessing Medicaid through a Supplemental Security Income (SSI) Waiver? ☐ YES ☐ NO
If YES, please see the Financial Information form in this C.A.R.E. Binder.

Are there any regular meetings in regard to insurance and/or waivers? ☐ YES ☐ NO

If YES, please provide details: