Intervention Center For Early Childhood

CHILD'S VERIFICATION AND ELIGIBILITY CHECKLIST:

Child's Full Name _____

Child's Date of Birth _____

Parent(s) Name or Responsible Party _____

Address _____

Phone Number (home) _____ (cell) _____

Employer _____

Insurance Carrier _____

Insurance Phone Number _____

Insurance I.D. Number _____

Are you currently in network with the client's insurance provider? Yes _____ No _____

Services to be Provided:

Speech Therapy_____ Physical Therapy_____ Occupational Therapy_____

MD Prescription must attached including diagnosis code

Copy of front & back of insurance card must be attached

Intervention Center for Early Childhood
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