

## Patient Eligibility Screening Form

Date \_\_\_\_\_

Child's full name \_\_\_\_\_

Date of birth \_\_\_\_\_

Parent, guardian's full name \_\_\_\_\_

Health care provider's full name                      Andover Pediatrics, P.C.

This form must be completed for all children under 19 years old and kept in the child's medical record or on file in the office for three (3) years. The form may be completed by the parent, guardian, or legal representative, or by the health care provider. This form should be completed only once, unless the child's insurance status changes

Check only one below

This child:

- \_\_\_\_\_ Is enrolled in Medicaid (includes Common Health and HMO's such as Neighborhood Health Plan, HPHC, Tufts Health Plan, etc if enrolled through Medicaid).
- \_\_\_\_\_ Does not have health insurance (also use this for children enrolled in the Children's Medical Security Plan).
- \_\_\_\_\_ Is Native American (American Indian) or Alaskan Native
- \_\_\_\_\_ Has health insurance (other than Medicaid) and is not Native American (American Indian) or Alaskan Native.

Please note that all children seen in Massachusetts practices get the same free vaccines. This form tells us which children get vaccines paid for by the state and other federal funds.

Child's name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Child's address \_\_\_\_\_ Telephone # \_\_\_\_\_  
(City/State/Zip) \_\_\_\_\_ Cell # \_\_\_\_\_  
\_\_\_\_\_ Email Address: \_\_\_\_\_

**INSURANCE INFORMATION:**

Subscriber name \_\_\_\_\_ Insurance company's name \_\_\_\_\_  
Subscriber address \_\_\_\_\_ Insurance company's billing address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Patient's ID # \_\_\_\_\_  
Patient's suffix # \_\_\_\_\_ Group name/# \_\_\_\_\_  
Co-payment amount \_\_\_\_\_ Effective Date \_\_\_\_\_  
Name of your child's primary care physician \_\_\_\_\_

**SOME INSURANCE COMPANIES REQUIRE A PCP SELECTION.  
PLEASE NOTIFY YOUR INSURANCE COMPANY OF YOUR SELECTION.**

**Patient Consent:**

I have read the Notice of Privacy Practices detailing my rights. I understand that medical information obtained by Andover Pediatrics, P.C. may be used for treatment, payment, quality assessments and case management.

I understand that I am responsible for providing Andover Pediatrics, P.C. and my insurance company with correct information to allow Andover Pediatrics, P.C. to bill for services rendered for my child. I authorize payment of benefits due to me be made directly to Andover Pediatrics, P.C. I also understand that there may be times when services will be provided which may or may not be a covered service and I accept full financial responsibility for these services.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date