Katie Beckett Unit
Office of Health and Human Services
Hazard Building (Bldg 074) –74 West Road, Ground Level
Cranston, R.I. 02920

INSTRUCTIONS FOR COMPLETION OF MEDICAL, DENTAL, VISION AND PRESCRIPTION COVERAGE THIRD PARTY LIABILITY (TPL) REPORTING FORM

Purpose: This information is used to verify **all** of the health, dental, vision and prescription coverage(s) a child may have and for EOHHS to maintain current information in its records.

The Office of Health and Human Services (EOHHS) policy requires the reporting of all changes to medical, dental, vision and prescription coverage(s) within 10 days of the change.

Please notify the Katie Beckett Unit within 10 days whenever any changes to these coverages occur, such as subscriber name, policy number, when coverage ends or when new coverage begins. The enclosed reporting form is double-sided to assist in reporting double coverage.

Additional copies of this reporting form are available under the Katie Beckett forms link at the Rhode Island Department of Human Services website: www.eohhs.ri.gov

Please include copies (front and back) of all health cards.

If additional information is required for the completion of these forms, please contact:

For initial applications:
If you child's last name begins with A-M please call Caridad Ramos at (401) 462-0760.
If you child's last name begins with N-Z please call Ann Murphy at (401) 462-0754.

For redeterminations:
Call Geraldine Anderson at (401) 462-0249

RI EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES KATlli BECKETT UNIT
MEDICAL (includes MEDICARE and TRICARE), DENTAL, VISION SERVICE PLAN (VSP)
and SEPARATE PRESCRIPTION COVERAGE REPORTING FORM

DATE:

CHILD'S NAME: DATE OF BIRTH:

CHILD'S SOCIAL SECURITY NUMBER:

PARENT/CAREGIVER: PHONE:

Please fill out all sections below. If no health insurance, put N/A.
Provide copies (front and back) of all Health Insurance Cards.

MEDICAL INSURANCE INSURANCE EFFECTIVE DATE:
INSURANCE COMPANY: PHONE:_____
POLICY ID NUMBER:_____ GROUP ID:
SUBSCRIBER NAME:_____ RELATIONSHIP TO CHILD:
SUBSCRIBER SSN:
EMPLOYER:

DENTAL INSURANCE INSURANCE EFFECTIVE DATE:
INSURANCE COMPANY: PHONE:_____
POLICY ID NUMBER:_____ GROUP ID:
SUBSCRIBER NAME:_____ RELATIONSHIP TO CHILD:
SUBSCRIBER SSN:

EMPLOYER:

SEPARATE VISION SERVICE PLAN (VSP) EFFECTIVE DATE:
INSURANCE COMPANY: PHONE:
POLICY ID'NUMBER:_____ GROUP ID:
SUBSCRIBER NAME:_____RELATIONSHIP TO CHILD:
SUBSCRIBER SSN: EMPLOYER:

SEPARATE PRESCRIPTION COVERAGE EFFECTIVE DATE:_____
INSURANCE COMPANY: PHONE:
POLICY ID NUMBER:_____ GROUP ID:
SUBSCRIBER NAME:_____ RELATIONSHIP TO CHILD:
SUBSCRIBER SSN:
EMPLOYER:

If this child has double medical, dental or other health coverage(s) (examples: Both parents have policies that cover the child or one parent has two or more policies, please provide additional information on the back of this fonn). Thank you.

Completed _____

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If your commercial insurance has changed, please contact the Third Party Liability Department at (40 I) 462-218 L

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MEDICAL (includes MEDICARE and TRICARE), DENTAL, VISION SERVICE PLAN (VSP)
and SEPARATE PRESCRIPTION COVERAGE REPORTING FORM'

DATE:

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S SOCIAL SECURITY NUMBER: _____

PARENT/CA REGIVER: _____ PHONE: _____

Please fill out all sections below. If no health insurance, put *N/A*.
Provide copies (front and back) of all Health Insurance Cards.

MEDICAL INSURANCE INSURANCE EFFECTIVE DATE:
INSURANCE COMPANY: PHONE: _____
POLICY ID NUMBER: _____ GROUP ID:
SUBSCRIBER NAME: _____ RELATIONSHIP TO CHILD:
SUBSCRIBER SSN:
EMPLOYER:

DENTAL INSURANCE INSURANCE EFFECTIVE DATE:
INSURANCE COMPANY: PHONE: _____
POLICY ID NUMBER: _____ GROUP ID:
SUBSCRIBER NAME: _____ RELATIONSHIP TO CHILD:
SUBSCRIBER SSN:
EMPLOYER:

SEPARATE VISION SERVICE PLAN (VSP) EFFECTIVE DATE:
INSURANCE COMPANY: PHONE: _____
POLICY ID NUMBER: _____ GROUP ID:
SUBSCRIBER NAME: _____ RELATIONSHIP TO CHILD:
SUBSCRIBER SSN:
EMPLOYER:

SEPARATE PRESCRIPTION COVERAGE EFFECTIVE DATE: _____
INSURANCE COMPANY: PHONE: _____
POLICY ID NUMBER: _____ GROUP ID:
SUBSCRIBER NAME: _____ RELATIONSHIP TO CHILD:
SUBSCRIBER SSN:
EMPLOYER:

Completed _____ Date: _____