

**RI EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES KATIE BECKETT UNIT
MEDICAL (includes MEDICAID 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 form). Thank you.

Completed by: _____ Date: _____

If your commercial insurance has changed, please contact the Third Party Liability Department at (401) 462-2181.

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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 by: _____

Date: _____