

**RI EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES KATIE 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.**

<b>MEDICAL INSURANCE</b>	<b>INSURANCE EFFECTIVE DATE:</b> _____
INSURANCE COMPANY: _____	PHONE: _____
POLICY ID NUMBER: _____	GROUP ID: _____
SUBSCRIBER NAME: _____	RELATIONSHIP TO CHILD: _____
SUBSCRIBER SSN: _____	(to be provided if child is approved)
EMPLOYER: _____	

<b>DENTAL INSURANCE</b>	<b>INSURANCE EFFECTIVE DATE:</b> _____
INSURANCE COMPANY: _____	PHONE: _____
POLICY ID NUMBER: _____	GROUP ID: _____
SUBSCRIBER NAME: _____	RELATIONSHIP TO CHILD: _____
SUBSCRIBER SSN: _____	(to be provided if child is approved)
EMPLOYER: _____	

<b>SEPARATE VISION SERVICE PLAN (VSP)</b>	<b>EFFECTIVE DATE:</b> _____
INSURANCE COMPANY: _____	PHONE: _____
POLICY ID NUMBER: _____	GROUP ID: _____
SUBSCRIBER NAME: _____	RELATIONSHIP TO CHILD: _____
SUBSCRIBER SSN: _____	(to be provided if child is approved)
EMPLOYER: _____	

<b>SEPARATE PRESCRIPTION COVERAGE</b>	<b>EFFECTIVE DATE:</b> _____
INSURANCE COMPANY: _____	PHONE: _____
POLICY ID NUMBER: _____	GROUP ID: _____
SUBSCRIBER NAME: _____	RELATIONSHIP TO CHILD: _____
SUBSCRIBER SSN: _____	(to be provided if child is approved)
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: \_\_\_\_\_