

NEVADA STATE HEALTH DMSION
BUREAU of FAMILY HEALTH SERVICES/MATERNAL and CHILD HEALTH
3427 Goni Road, Suite 108
Carson City, Nevada 89706
PH 7756844285 FAX 7756844245

Insurance Co. name & address:

Insured: _____

Thru: _____

Policy # _____

Patient: _____

Date: _____

Gentlemen:

Please be advised that the above named client has applied for assistance with the Family Health Services/MCH program. Since insurance is classified as a prior resource to governmental programs, this office would appreciate the following information:

1. Date insurance became effective _____
2. Date insurance terminated _____
3. Does insured have dependent coverage? _____
4. Will your insurance company cover medical care that is necessary and appropriate for this patient, including pregnancy? _____
5. A. Any pre-existing conditions? _____
B. Length of pre-existing limit? _____
6. Specific policy limitations, medical and/or payment, i.e. preferred providers _____

Family Health Services

I agree to the above request and authorize the insurance company to release the information requested to the State of Nevada Family Health Services /MCH Program so that they may process this case for approved services

Insured(s) representative

Relationship

Date