Ohio Department of Health

Attention Parents With Health Insurance

This form is to be used to report changes to the Bureau during your child's authorization period. Please keep this form with your child's letter of approval.

If your child has medical coverage through a private insurance company, your insurance is the primary source of payment for your child's medical care. This means that, by state law, your child's providers must bill your insurance company and obtain either a payment or a rejection before billing BCMH.

Many insurance companies now require pre-approval of services. Please be sure to get pre-approval and do everything necessary to fully utilize your insurance coverage. **BCMH will not pay for services rejected by your insurance company for a failure to obtain pre-approval. You must also stay within your insurance network, if possible.**

Please review the insurance information on the enclosed Letter of Approval (LOA). Make sure that the insurance company is correct and that all the items listed with 'insurance' as the source of payment are covered by your policy. Please use this form to let us know if any of the insurance information on the LOA is incorrect or if there are changes in your child's coverage. When reporting changes, please send a copy of the insurance card, if possible.

Name of child/client	
BCMH case number	Birthdate of client

Health insurance company	Telephone number
Policy holder	

Policy number	Group number	Effective date

Is this child's coverage limited by a pre-existing condition clause? ☐ Yes ☐ No

If yes, please attach a copy of the pre-existing clause.

Does your plan include a prescription drug benefit? ☐ Yes ☐ No

What is the name of your drug plan and phone number if different from above?

Name of plan	Phone number

Do you use a mail order service? ☐ Yes ☐ No

Is it required or voluntary? ☐ Yes ☐ No

Do you have dental insurance? ☐ Yes ☐ No

What services are not covered by your insurance?

If your insurance has terminated and you currently have no coverage,

Check this box ☐ Date terminated

Mail To: Bureau for Children with Medical Handicaps
P.O. Box 1603
Columbus, OH 43216-1603

Thank you

Ohio Department of Health

Attention Parents With Medicaid

This form is to be used to report changes to the Bureau during your child's authorization period. Please keep this form with your child's letter of approval.

If your child has a medical card, most of your child's medical bills will be covered by Medicaid. BCMH families who are eligible for Medicaid are required to use Medicaid. However, it is a good idea to stay enrolled on BCMH in case there is a gap in your child's Medicaid coverage. Also, BCMH pays for some services, such as visits by a nurse from your local health department, that are not covered by Medicaid.

If you receive Medicaid coverage through a Medicaid-HMO, please be sure to get pre-approval for your child's medical care and do everything necessary to fully utilize the Medicaid-HMO benefits. **BCMH will not pay for services rejected by a Medicaid-HMO for a failure to obtain pre-approval.**

Please use this form to let us know if you Medicaid coverage stops or if the kind of Medicaid you have changes. Also, tell us if your child gets a new Medicaid recipient identification number.

Name of child/client	
BCMH case number	Birthdate of client

If Medicaid coverage stopped, on what date did it end? month-day-year

You must send a copy of your denial letter to BCMH as soon as you receive it.

If your child has been put on a monthly spend-down, what is the amount of the spend-down? $

If your child was given a new Medicaid recipient identification number, what is the new 12-digit number?

Is your child's Medicaid coverage provided by a Medicaid HMO? ☐ Yes ☐ No

Name of HMO	Phone number of HMO

If there have been other changes in your child's Medicaid coverage, what are they?

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Columbus, OH 43216-1603