

MISSOURI DEPARTMENT OF SOCIAL SERVICES

FAMILY SUPPORT DIVISION

**MO HEALTHNET FOR KIDS INSURANCE COMPANY QUOTES**

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| **FROM** | **OFFICE ADDRESS** | DATE  December 8, 2015 |
| MO | PHONE NUMBER |
| **TO** | NAME | CASE NAME |
|  | ADDRESS (STREET OR P.O. BOX NO.) | DCN NUMBER |
|  | CITY STATE ZIP |  |

The MO HealthNet for Kids program requires that you get two quotes from private insurance companies on the cost for health insurance for your children. This form must be filled out by you, based on information that you get from the insurance companies. Please complete the form and return to the Family Support Division at the address above, or fax the form to    -   -    . An eligibility specialist may contact the insurance company to verify the information you provide.

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Contact at Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the policy provide coverage for all the following services? You must mark either “Yes” or “No” for each listed item.

Yes No Yes No

Physician Care   Allergy diagnosis and treatment

Hospital – inpatient and outpatient   Mental Health: Outpatient counseling

Prescription drugs   Mental Health: Inpatient psychiatric care

Maternity care

(Must include prenatal, labor & delivery,

and postpartum services Substance abuse / chemical dependency:

Emergency care, including ambulance   Outpatient counseling

Preventative care:   Inpatient treatment

Well-baby and pediatric care   Diagnostic (including lab and x-ray)

Routine physicals   Durable medical equipment, prosthetics

Immunization   Hospice

Vision exams and care   Home health and personal care

Hearing exams and care   Transplants

Dental exams and care   Therapy – occupation, physical and speech

Total Monthly Premium to cover ONLY children: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any pre-existing conditions the policy will not cover?  YES  NO

If yes, please explain:

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Signature: Date: