

MISSOURI DEPARTMENT OF SOCIAL SERVICES

FAMILY SUPPORT DIVISION

**MO HEALTHNET FOR KIDS INSURANCE COMPANY QUOTES**

|  |  |  |
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| **FROM** | **OFFICE ADDRESS**  | DATEDecember 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: