PA Act 62 of 2008

Private Insurance Coverage for Children with Disorders on the Autism Spectrum

Recipients Coverage Certification Form

Part I. Recipient Information

_____

First Name Middle Initial Last Name

_____

Date of Birth

_____

SSN

_____

Medical Assistance Identification Number

_____

Street,

_____

City, State, Zip

Part 2 Insurance Coverage

_____

Name of Insured (First Name, Middle Initial, Last Name)

_____

Employer (name and address)

_____

# of Employees at Employer

_____

Name of Insurance Company

_____

Plan I.D. #

_____

Group Plan I.D. #

Part 3 To be Completed by Employer

Please answer each question. Please attach additional documentation if necessary.

1. Is the insurance plan issued or renewed in the Commonwealth of PA?

    - o Yes
    - o No

2. Are 51 or more employees covered by the employer's health plan?
   (does not include employees at associational plans)
   - o Yes
   - o No

3. The plan is NOT self insured (a.k.a. self funded) .

   - o Yes
   - o No

If you answered no to any of the above questions, coverage of autism is *not* required under PA Act 62. However, coverage is strongly encouraged. (Please skip to Part 4.)

If you answered yes to all of the above questions, please complete the following:

A. Date that Plan Renews During 2009: _____
B. 1st Date of Coverage for Above Named Recipient During 2009: _____

Please enter the *later* of the dates from A, B or July 1, 2009: _____

This is the date that your plan is required to begin providing coverage for autism related services for the above named recipient.

Part 4

I, _____ as a representative of _____ certify that our company is contracted with an insurance company that is either

_____ a.) required to provide coverage for autism related services

_____b.) not required to provide coverage for autism related services

_____c.) chooses voluntarily to provide coverage for autism related services.

_____ _____
Name Date