Child's Insurance

Primary

Parent/Guardian ______________________

Child's Name______________ Date of Birth ______________

Insurance Company ______________________

Address ____________ City____________State _____ Zip ________

Contact/Phone # ______________________

Name of Insured __________ Policy # __________ Group # __________

Policy Effective Dates ______________________

Employer Name ______________________

Address ____________ City____________State _____ Zip ________

Secondary

Parent/Guardian ______________________

Child's Name______________ Date of Birth ______________

Insurance Company ______________________

Address ____________ City____________State _____ Zip ________

Contact/Phone # ______________________

Name of Insured __________ Policy # __________ Group # __________

Policy Effective Dates ______________________

Employer Name ______________________

Address ____________ City____________State _____ Zip ________

Coverage

What is covered and co-pay for the following:

Procedure	Covered	Co-Pay
Doctor's Office Visits		
ER Care		
Surgeries		
Outpatient Hospital Care		
Doctor's Hospital Visits		
Hospitalizations		
Durable Medical Equipment		
Orthotic/Prosthetic Devices		
Medical Supplies		
Prescribed Medications		
Home Care		
Skilled Nursing Care		
Medical Treatment		
Therapy (kind)		
Other		
Diagnostic Tests		
Laboratory		
X-rays		
Other		
Ambulance		
Dental Care		
Mental Health Care		
Inpatient		
Outpatient		

What is not covered by insurance:

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Notes

Medical Bill Tracking Form

Date	Provider	Service	Cost	Insurance Company Paid/Date	Family Paid/Date

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Child's Name ______________ **Date of Birth** / /

Date Last Revised: ______________

Income Tax Expense Record

Date	Expenses	Medical	Travel (To/From/Mileage/Other)	Cost

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Child's Name ____________ **Date of Birth** / /

Date Last Revised: ____________