Cincinnati Children's

Endocrinology

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Dear Parent/Guardian,

Attached is an application for coverage provided by the Ohio Department of Health's Bureau for Children With Medical Handicaps. BCMH is an insurance program set up by the State of Ohio to help defray the cost of medical treatment to families who have children with medical handicaps.

This paperwork is optional. You have nothing to lose by applying for this program. Your insurance will pick up the cost first, and then any secondary insurance you may have. BCMH is the last line of defense against out of pocket medical expenses.

When filling out the attached form, please complete **ALL 3 PAGES**, including the Release of information form from CCHMC. It ensures we have your permission to include medical information with your application. Failure to complete **ALL 3 PAGES** will delay your application and possible coverage.

Please be sure to sign the documents before returning them to me.

Thank you,

Jean Lerma
Endocrinology
BCMH Processor
513-636-8440
Jean.Lerma@cchmc.org

Cincinnati Children's
Hospital Medical Center

To: Parents of Endocrine/Diabetes patients
From: Division of Endocrinology and Diabetes

Enclosed is a description of services offered through the Ohio Bureau for Children with Medical Handicaps (BCMH). It is a state-funded program that may help pay medical bills. There are two different types of programs offered, Diagnostic and Medical Treatment.

The Diagnostic Program is a program offered that provides services to rule out a chronic condition, determine a diagnosis or establish a plan of treatment for a child with certain medical conditions. The following is a list of eligibility guidelines:

- Under the age of 21; A resident of Ohio; A permanent US resident **OR** US born; has a possible medical condition; and under the care of a BCMH approved physician.

There are no financial eligibility requirements for the Diagnostic Program. A child may receive up to three months of diagnostic services through this program. An extension of this time period may be given if requested by the BCMH approved physician. If the child is on Medicaid, Medicaid will pay first. If the child is covered by insurance, the insurance will pay first. BCMH will be billed the balance from Medicaid or the insurance. If the child has neither a medical card nor insurance, BCMH will pay for all authorized services.

Eligible services available on the Diagnostic Program include:

- Consults and office visits to an approved BCMH physician; dental consults; up to five days inpatient hospitalization; laboratory tests; special tests; x-rays; interpretation of test/x-rays; biopsies; OT, PT and Speech evaluations; psychological evaluations for children with potentially handicapping physical problems; and public health nurse services.

Conditions and services which are **NOT** eligible on the Diagnostic Program include:

- Acute illness, such as colds, flu, appendicitis and trauma; emotional and behavioral problems; routine well child care; physical and psychological examinations for school or adoptive placement; sports physical exams; nearsightedness or farsightedness; evaluation of learning difficulties; medications; and equipment and services provided by non-BCMH providers.

The Medical Treatment Program is to provide ongoing treatment services for eligible children. You must be financially eligible for this program. BCMH uses your gross income to determine your eligibility. Do not let your income stop you from applying for assistance. Many middle income families do qualify for coverage due to adjustments of gross income and the cost share program. We encourage everyone to apply.

To apply for the Diagnostic and Treatment Programs, please fill out the white BCMH Medical Application forms (lines 1-25 and line 47) and sign the bottom of the back page were indicated. Please bring the application to your appointment with you!

Please call with any questions or concerns. Diabetes patients, contact Tamika Poole at (513) 636-8644. Endocrine patients, call Agie Lerma at (513) 636-8440. Our toll free number (800) 344-2462.

Thank You.

Cincinnati Children's Hospital Medical Center

Authorization for Use and/or Disclosure of Protected Health Information

MEDICAL RECORD #: _____ *(completed by CCHMC)*

This form authorizes Cincinnati Children's Hospital Medical Center to use and/or disclose protected health information in the manner described below and is voluntary. Cincinnati Children's will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations.

Please note that each section of the form must be completed in its entirety. *Failure to specify (including dates) will delay the processing of your request.*

Patient Information

Patient Name: _____ Gender: ☐ Male ☐ Female
Last First Middle Maiden (if applicable)

Date of Birth: _____ Phone: ( ) _____

Parent/Guardian/Requestor Completing Form: _____

Requestor Email Address (optional): _____

Note: Email addresses will be utilized strictly to facilitate the processing of your request. No protected health information will be conveyed in this manner.

Release To

Name: _____ Organization (if applicable): Ohio BCMH

Street Address: P.O. Box 1603

City/State: Columbus, OH Zip Code: 43216-1603 Telephone: (614) 466-1700

Information May Be: ☒ Mailed ☐ Reviewed Only ☐ Discussed via Telephone ☐ In Person Meeting ☐ Picked Up By: _____

Requests greater than 500 pages will be provided in an electronic format saved to disc unless specifically requested to be on paper.
For copy requests greater than 100 pages, the requestor may choose to receive the medical record on a disc at a 50% discount. If you would like the record provided in an electronic format, please indicate by checking one of the following: ☐ Yes ☐ No

Purpose

Records are to be released for the following purpose(s): *(Select all that apply)*

☐ Medical Care ☐ Attorney/Legal ☐ Personal ☒ Insurance ☐ Disability/SSI ☐ Other: _____

Information to Release

Dates of Treatment/Particular Illness/Admission Requested: last visit

☐ Patient/Physician Abstract – pertinent information generally used for continued care/personal use.
(See the reverse of this form for information regarding what is included in a Patient/Physician Abstract.)

☐ Discharge Summary ☐ Emergency Department Record ☐ X-Ray Reports, Labs or Other Tests
☐ History & Physical ☐ Immunizations ☐ Consultation Reports, Specify MD: _____
☐ Operative Reports ☐ Registration Sheets ☒ Outpatient Clinic Notes, Specify Clinic(s): Endocrinology
☐ Other: _____
Note: Psychotherapy notes must be requested through a separate authorization.

Patient/Parent/Legal Guardian Authorization

Unless otherwise revoked, this Authorization will expire one (1) year from the date it is signed or, if specified, on the following date, event or condition (complete if desired): _____. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department at the address below. Please refer to Cincinnati Children's Notice of Privacy Practices. If Cincinnati Children's requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

I, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information from my (or give relationship) child's medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Signature of Patient: _____ Date: _____
(if 18 years of age or older OR is an emancipated minor)

Signature of ☐ Parent/ ☐ Legal Guardian (check one): _____ Date: _____
Note: If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.

Submit

Please verify that all sections are completed in full. Upon completion, please send the form to:

Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue, ML 5015
Cincinnati, Ohio 45229-3039

OR

Fax the form to: (513) 636-6729

Request Has Been Fulfilled: ☐ Yes, Initials _____ Date _____

DTM1000

PLEASE PRINT

Ohio Department of Health
Medical Application

Bureau for Children With Medical Handicaps, 246 North High Street, P.O. Box 1603, Columbus, Ohio 43216-1603

☒ Diagnostic ☒ Treatment ☐ Case Renewal ☐ Service Coordination ☐ PHN Referral ☐ Adult Hemophilia

∗1. Child's/Client's name (last, first, mi)			2. Case number (child's/client's)	
∗3. Address			∗4. County	
City		∗State	∗ZIP	Health department code
∗5. Child's/Client's birthdate	∗6. Social Security number (child's/client's)	∗7. Sex ☐ 1. Male ☐ 2. Female	∗8. Ethnic group	9. Ohio resident ☐ 1. Yes ☐ 2. No
∗10. Parent's/Legal guardian's/Client's name (last, first)		∗15. Parent's/Legal guardian's/Client's name (last, first)		
∗11. Address		∗16. Address		
∗City	∗State ∗ZIP	∗City	∗State	∗ZIP
12. Social Security number		17. Social Security number		
∗13. Home phone ( )	∗14. Work phone ( )	∗18. Home phone ( )	∗19. Work phone ( )	

Insurance Information

FOR BCMH USE ONLY

∗20. Health insurance coverage ☐ 1. Yes ☐ 2. No	Policy number	Begin date	End date	Carrier number
Health insurance company name		Name of insured		
∗21. Health insurance coverage ☐ 1. Yes ☐ 2. No	Policy number	Begin date	End date	Carrier number
Health insurance company name		Name of insured		
22. Dental insurance coverage ☐ 1. Yes ☐ 2. No	Carrier number	Begin date	End date	
Dental insurance company name		Name of insured		
23. Vision care insurance coverage ☐ 1. Yes ☐ 2. No	Carrier number	Begin date	End date	
Vision care insurance company name		Name of insured		

∗24. Medicaid eligible ☐ 1. Yes ☐ 2. No	∗Medicaid recipient/Billing number	Begin date	End date	25. S.S.I. eligible ☐ 1. Yes ☐ 2. No

∗26. Managing physician's/Service coordinator's name: Division of Endocrinology/Cincinnati Children's Hospital			Site ☐ Private office ☒ Clinic
∗27. Address: 3333 Burnet Avenue, MLC 7012			28. Telephone number: (513) 636-4744
∗City: Cincinnati	∗State: OH	∗ZIP: 45229-3039	∗29. Provider number

∗30. Primary diagnosis	∗I.C.D. code	∗31. Secondary diagnosis	∗I.C.D. code
∗32. Tertiary diagnosis	∗I.C.D. code	∗33. Quaternary diagnosis	∗I.C.D. code

∗DATA REQUIRED IN ORDER TO PROCESS

HEA 7115 12/08

Child's/Client's name	Case number

34. If child/client has any other handicapping condition(s), please describe

35. Name of primary care physician	36. Name of primary care dentist

37. Major Services

Category of service	Name and address of provider	Provider number	Unit of service	Source of payments

38. Recommendations (Include/attach Plan of Treatment, Medical Report and/or Discharge Summary.)

*39. Managing physician's/Service coordinator's signature	*Date	*40. Initial date of exam

*Print physician's name

41. Name of person completing form	Telephone ( )	*42. Most recent date of exam

Public Health Nurse Referral

43. Name	44. Health department	45. Telephone ( )

46. Reason	Date of scheduled exam

I hereby authorize the managing physician or service coordinator listed above to submit this application to the Ohio Department of Health, Bureau for Children with Medical Handicaps (hereinafter referred to as "BCMH"), for services for the child/client (hereinafter referred to as "client") named on the front of this application. I authorize BCMH to release confidential information concerning the client's medical condition and treatment, any and all financial information and third-party coverage to county and/or city health departments located in the city or county where the client lives or receives treatment and to health care and service providers, facilities and third-party payors (and their agents and employees) for the purposes of providing or facilitating the delivery of or arranging for services to the client. This authorization includes the release of any and all information concerning the client's medical conditions and treatment, including if applicable, the client's HIV testing or diagnosis of AIDS or AIDS-related conditions.

I certify and attest that all the information given by me on this form and other BCMH application forms is true and accurate. I hereby give my permission to have all financial information verified. I authorize the release to BCMH of any and all information pertaining to my contract of insurance as to claims filed on behalf of client and amounts paid and to whom these claims or amounts were paid.

This release authorization is effective from the date of my signature and will remain in effect until such time as I expressly revoke it in writing. I understand that the above-referenced information will not be released to any other entity without an additional written release authorization from me or other person having legal authority to provide such release or as required by law.

I have read this authorization to release information and fully understand its contents.

*47. Parent's/Guardian's/Client's signature	*Date
*Print name	*Relationship to child/client

48. Approved ☐ 1. Yes ☐ 2. No	49. Program	Code	50. Effective date	51. Expiration date

52. Denial reason	Code	53. Denial reason	Code

54. Nurse case manager	Date

*DATA REQUIRED IN ORDER TO PROCESS

Completion of Medical Application Form (MAF) HEA 7115

Information required for processing is marked with an asterisk (*). MAF's that are incomplete or illegible will be returned to the sender.

Front of MAF:

- Check appropriate box at top of form (diagnostic, treatment, case renewal, service coordination, PHN referral, adult hemophilia, HMG/Help Me Grow pilot). A separate MAF is required for each program requested.
- If the child/client has a sibling who is currently on the BCMH program or has recently been on the program, indicate sibling's name, case number, or date of birth at the top of the MAF.
- Complete all demographic information and identifying information about the child/client and family (boxes 1–19).
- Complete "insurance information" section (boxes 20-25). Information on the primary health insurance for the client, Medicaid status and Medicaid recipient number is required.
- Identify the physician/service coordinator by first and last name (box 26), site of the visit, address (box 27), telephone number (box 28) and BCMH provider number (box 29).
- Fill in eligible diagnoses and ICD code numbers (box 30-35).

Back of MAF:

- Fill in child/client's name and case number, if known.
- Provide information about other handicapping conditions (box 34).
- Fill in the name of the child/client's primary care physician (box 35) and primary care dentist (box 36).
- In box 37, list major services needed and the provider for each service (i.e., "surgery/special procedure: name of surgeon and name of facility; in-patient hospital stay: name of hospital). All services must be provided by a BCMH provider. However, in many cases the name of the provider is not required on the MAF. This would include services such as therapy services, eye glasses, hearing aids and medical supplies.
- A medical report, plan of treatment and/or a discharge summary should be attached to the MAF.
- The managing physician must sign and date the form and print his/her name (box 39). If the MAF is an application for service coordination, the service coordinator must sign and date the form.
- The initial date of exam (box 40) and the most recent date of exam (box 42) are necessary to establish the effective dates for BCMH services and are, therefore, required data.
- The name of the person completing the form should be entered in box 41. This is helpful should there be questions regarding the MAF.
- If the MAF is a PHN Diagnostic Referral, boxes 43–46 must be completed by the PHN.
- The parent, guardian or client, if over 18 years of age, must sign and date the form and complete other information requested in box 47. BCMH cannot process the MAF if the Release and Consent statement is not signed.
- BCMH requires the signature of a client who is the legal age of 18 years of older, unless the client is not medically able to sign, in which case a notation as to why the client is unable to sign should be made.