Child's Insurance

Primary

Name on Insurance _____

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

Name on Insurance _____

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:

_____

_____

_____

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: _____

Medical Bill Tracking Form

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

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Date Last Revised: _____

Income Tax Expense Record

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

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Date Last Revised: _____

Notes