Dr. Brena M. Desai

PEDIATRICIAN PC.

Insurance Confirmation Questionnaire

Today's Date: _____

Patient Name: _____

Date of Birth: _____

1. What insurance does your child have today? _____

2. Is your child added to any other insurance? Please circle: **Yes** **No**

   If yes, what is the name of the insurance? _____

   Please provide insurance card.

3. Please provide CIN# (Medicaid or Benefit#), if your child has Health First, Health Plus, Metro Plus, HIP Medicaid, Fidelis, Affinity, United Healthcare Community Plan.

   _____

4. Is your child added/enrolled to either parent's insurance through job?

   Please circle one: **Yes** **No**

   If yes, please provide the information.

Print Name: _____

Signature of Parent/Guardian: _____

Signature of Patient (if 18+): _____