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 ☐ HMG

*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				Site ☐ Private office ☐ Clinic
*27. Address				28. Telephone number ( )
*City		*State	*ZIP	*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 (Rev. 12/03)

Child's/Clients 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