NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

REQUIRED NOTICE OF SUBROGATION
Pursuant to Section 2559(3)(d) of the New York State Public Health Law and Section 3235-a(c) of the New York State Insurance Law

Insurer's Name
Address

Section 2559(3)(d) of the Public Health Law (PHL) states that a municipality, or its designee, and a provider shall be subrogated, to the extent of the expenditures by such municipality or for early intervention services furnished to persons eligible for benefits under this title, to any rights such person may have or be entitled to from third party reimbursement. The provider shall submit notice to the insurer or plan administrator of his or her exercise of such right of subrogation upon the provider's assignment as the early intervention service provider for the child. The right of subrogation does not attach to benefits paid or provided under any health insurance policy or health benefits plan prior to receipt of written notice of the exercise of subrogation rights by the insurer or plan administrator providing such benefits.

Section 3235-a(c) of the Insurance Law states that a right of subrogation exercised by providers under Section 2559(3)(d) of the PHL is valid and enforceable against the insurer to the extent of benefits available under the insurance policy, plan or benefit package.

As the insurer of ______________________________________, you are obligated to accept claims submitted by ____for services provided for which benefits are available to the child.

This subrogation notice should be maintained on file by the insurer to ensure that claims for services provided to the child and covered under a policy, plan or benefit package are reimbursed to me, as the child's Early Intervention Program Service Provider and not to the municipality or to the child's parent/guardian.

____ is hereby notifying ____ of the intent to exercise subrogation rights pursuant to the aforementioned sections of NYS Public Health and Insurance Law. I intend to claim reimbursement for services provided that are included in the Individualized Family Service Plan and for which the above named child as the insured is eligible.

Early Intervention Service Provider:	
Child's Member ID #:	
Policy # (for billing):	
Child's Name:	Date of Birth:
Policy Holder Name/Relation to Child:	Date of Birth:

If you have any questions, please contact:

Provider: ____

Provider Address: ____

Phone Number: ___________________________ Date: _______________