NEW YORK STATE | Medical Indemnity Fund

NYS MEDICAL INDEMNITY FUND APPLICATION

ENROLLMENT INFORMATION

(1) Applicant Last Name: First: Middle:	(2) Social Security #: _____ (3) Birth Date: / / (4) Gender: MALE / FEMALE/ GENDER X
(5) Street Address: City: State: Zip:	
(6) Parent/Guardian Name: Phone number: Email address:	
(7) Diagnosis/Diagnoses:	
(8) Preferred Language: ❑English ❑Spanish ❑Other_____	
(9) Is Applicant a Medicaid recipient? ❑ Yes ❑ No	
(10) If answer to question 9 is YES, please provide the Applicant's Medicaid Number:	

If the answer to any or all of the questions 11, 12 or 13 below is YES and you have submitted the requested information as part of applying for or enrolling in another health care program, you may submit a copy of the prior application or enrollment form to answer these questions as long as the information is still current.

(11) Is the Applicant receiving services from any other government program such as Early Intervention, Preschool Supportive Health Services and Access-VR (formerly known as VESID)? ❑ Yes ❑ No
(12) If the answer to question 11 is YES, please provide what other program or programs provide(s) services to the Applicant and the name and phone number of the Applicant's contact person for each such program. Please provide documentation of all other present sources of health care coverage or reimbursement relating to government program(s).

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(13) Is the Applicant covered by other health insurance? ❑ Yes ❑ No

(14) If the answer to question 13 is **YES,** please provide the name, address and phone number of the Applicant's health insurer and the subscriber or membership number used to submit claims on behalf of the Applicant:

Please provide documentation of all other present sources of health care coverage or reimbursement relating to other health insurance.

(15) Please provide the name, phone number, and relationship to Applicant of every person authorized to obtain and submit information on behalf of the Applicant:

(16) Please provide the name, address and phone number of every provider from whom the Applicant is currently receiving health care services, **on the last page of this form**. If you have submitted this information as (a) part of applying for or enrolling in another health care program or (b) as part of a medical malpractice lawsuit and the information is still current, you may submit a copy of the prior application or enrollment form or the relevant portion of such form to satisfy this requirement.

(17) To complete your application, please provide the following documents:

- ✓ Certified copy of the judgment or court-approved settlement that found or deemed the Applicant to have sustained a birth-related neurological injury on or after April 1, 2011, including all documents and/or exhibits referenced in the settlement or judgment
- ✓ Authorization for Release and Use of Medical Information Form
- ✓ Summary provided by the treating physician regarding the specific nature and degree of the applicant's birth-related neurological injury or injuries, including diagnoses and impact on the applicant's activities of daily living and instrumental activities of daily living, for example: a copy of the long-term plan of care, etc.
- ✓ In the event that you appoint an authorized representative or attorney to interact with the Fund, please provide a copy of that agreement.

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If you are submitting this form on behalf of the Applicant, please check the appropriate description of your relationship to the Applicant.

Parent ❑ Guardian Ad Litem ❑ Defendant in malpractice action ❑ Guardian ❑ Attorney ❑

Name, Address and Phone number of Parent or Other Person(s) Legally Authorized to Apply on Behalf of Applicant:

Signature of Parent or Other Person Legally Authorized to Apply on Behalf of the Applicant

Date

List of Applicant's Current Healthcare Providers:

Name	Address	Phone Number	Specialty