



~~Notification to the  
Department of Medical Assistance Services:  
Family Declining to Bill Private Insurance~~

~~The parent(s) of \_\_\_\_\_ (child's name) has declined  
access to their private health/medical insurance for covered early intervention services.~~

\_\_\_\_\_  
~~Name of Local Part C System Representative~~

\_\_\_\_\_  
~~Signature of Local Part C System Representative~~

\_\_\_\_\_  
~~Date~~