## Request for Certification of Disabled Dependent



The "Request for Certification of Disabled Dependent" form is used to determine if your dependent child meets the group's eligibility requirements for continued coverage after the age limits are reached.

Please complete the form. The second half must be completed by the physician or specialist most familiar with the nature of the disability.

In addition, please include the following information and attach it to the form:

- Your dependent's most recent medical history (must be within 12 months)
- Physician's most recent exam notes and history addressing the disability
- Assessment of your dependent's functional level (including employment capability, education and daily activities)
- Clinical findings (such as results of specialized exams, physical or mental)
- Laboratory findings
- Treatment prescribed and prognosis
- If your dependent has been awarded Social Security benefits, please attach a copy of the Social Security Income (SSI) award letter.

Examples of acceptable sources for the information include licensed physicians, licensed or certified psychologists, and licensed optometrists.

You or your physician may submit the information, along with the completed and signed "Request for Certification of Disabled Dependent" form, to the following address:

Premera Blue Cross Membership & Billing, MS 737 PO Box 3048 Spokane, WA 99220

When this information has been received, it will be reviewed by our medical department for a determination of future coverage. If additional medical information is required, we will contact you or the physician.

If you have questions regarding the attached form, please call Customer Service at 800-722-1471.

## Request for Certification of Disabled Dependent

Membership & Billing, MS 737 PO Box 3048 Spokane, WA 99220



## 1. Employee — Complete this part

Me	mber ID:		Group number:				
Las	t name:		First name:			M.I:	
Str	eet address:		City:		State:	ZIP:	
Naı	me of dependent:	Relationship to	Relationship to employee:   Son Daughter Other:				
Birth date: Age when disability occurred:			Marital status:	Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced			
Α.	Is this dependent covered by Medicare?	If yes, please list his/her Sc	ease list his/her Social Security number:				
В.	Do you support this dependent?	□ No □ Yes	If yes, what amount?	%			
C.	Does this dependent reside with you?	□ No □ Yes	If no, why?	_			
D.	Dependent address if different than subs	criber:					
E.	Is this dependent chiefly dependent on y	ou for support ar	nd maintenance?	□ No □ Yes			
F.	If this dependent is 18 or older, has a cou	ırt appointed you	his/her legal guardian?	□ No □ Yes	If Yes, ple court doo	ease attach a copy of cumentation.	
G.	Has this dependent ever been employed	? □ No □ Yes	Now employed?	□ No □ Yes			
	Please provide dependent's employment	information (use	additional paper if necessary	<i>'</i> ):			
	Employer's name	Employer's ad	Idress	Position held	Date	es of employment	
	1.						
	2.						
l ce	ertify that this information is correct to the	pest of my know	ledge.	1			
X							
2.	ployee must sign	e the responsible	ility of the subscriber			Date signed	
2.		•	D			Date signed	
2. Phy	Physician—Complete below  Any fee for the completion of this form i	•	D		State:	Date signed	
2. Phy	Physician—Complete below Any fee for the completion of this form i	·	Degree:	□ No □ Yes	State:		
2. Phy	Physician — Complete below Any fee for the completion of this form i	taining employm	Degree: City: ent due to disability?	□ No □ Yes	State:		
2. Phy Stre	Physician — Complete below Any fee for the completion of this form in expect address:  Is dependent above incapable of self-sus	taining employm lent reached the	Degree:  City:  ent due to disability?  plan's limiting age?  ns using as much detail as	□ No □ Yes  possible. Attach m	nedical reco	ZIP:	
2. Phy Stro A. B.	Physician — Complete below Any fee for the completion of this form is residual name:  Deet address:  Is dependent above incapable of self-sus Did the disability exist before the dependent and the disability in an attached letter, please address the within the past 12 months (to include the	taining employm lent reached the re following iter most recent cor	Degree:  City:  ent due to disability?  plan's limiting age?  ns using as much detail as	□ No □ Yes  possible. Attach m	nedical reco	ZIP:	
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Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.