Request for Certification of Disabled Dependent

PREMERA | BLUE CROSS

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.

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Request for Certification of Disabled Dependent

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

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1. Employee—Complete this part

Member ID: _____ Group number: _____

Last name: _____ First name: _____ M.I: _____

Street address: _____ City: _____ State: _____ ZIP: _____

Name of dependent: _____ Relationship to employee: ☐ Son ☐ Daughter ☐ Other: _____

Birth date: _____ Age when disability occurred: _____ Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

A. Is this dependent covered by Medicare? ☐ No ☐ Yes If yes, please list his/her Social Security number: _____

B. 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 subscriber: _____

E. Is this dependent chiefly dependent on you for support and maintenance? ☐ No ☐ Yes

F. If this dependent is 18 or older, has a court appointed you his/her legal guardian? ☐ No ☐ Yes

If Yes, please attach a copy of court documentation.

G. Has this dependent ever been employed? ☐ No ☐ Yes Now employed? ☐ No ☐ Yes

Please provide dependent's employment information (use additional paper if necessary):

Employer's name	Employer's address	Position held	Dates of employment
1.			
2.			

I certify that this information is correct to the best of my knowledge.

X _____ _____

Employee must sign Date signed

2. Physician—Complete below

Any fee for the completion of this form is the responsibility of the subscriber.

Physician name: _____ Degree: _____

Street address: _____ City: _____ State: _____ ZIP: _____

A. Is dependent above incapable of self-sustaining employment due to disability? ☐ No ☐ Yes

B. Did the disability exist before the dependent reached the plan's limiting age? ☐ No ☐ Yes

C. Nature of disability

In an attached letter, please address the following items using as much detail as possible. Attach medical records pertaining to the disability within the past 12 months (to include the most recent complete physical, functional, and communicative evaluative documentation, laboratory and clinical findings).

- ICD Code(s) that is the handicapping condition: _____
- Identify the current treatment for identified symptoms and functional impairments.
- Is the disability ☐ **temporary** or ☐ **permanent**? If temporary, what is the estimated time frame for the disability? _____

  If **permanent**, provide rationale for that status: _____
- Provide a description of both current and chronic specific symptoms and functional impairments that render the individual incapable of self-sustaining employment and a clear explanation of how those symptoms and functional impairments in fact render the individual unable to sustain employment. If the individual is currently employed, please describe the job responsibilities and explain why this individual should be considered incapable of self-sustaining employment when he/she is in fact employed.

D. Medical Records

Attach medical records pertaining to the disability within the past 12 months (to include the most recent complete physical, functional, and communicative evaluative documentation and laboratory and clinical findings).

X _____ _____ _____

Signature of Physician Date signed Date of last evaluation

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.

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