Certification for a Mentally or Physically Disabled Dependent Child Over Maximum Age

Anthem BlueCross BlueShield

HealthTrust

Instructions:

When answering questions on this enrollment application (other i.e. "health statement" etc) the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Section 1: Member/Employee information

Last name	First name		Anthem ID no.
Address	City	State	ZIP code
Company/Employer name	Group no.	Member email address	

Do you claim this dependent on your Federal Income Tax? ☐ Yes ☐ No Note: Your dependent must be claimed on your Federal Income Tax to be eligible.

☐ 1040 tax filing attached – 1040 tax filing information is required for processing. Forms will not be processed without this information.

Section 2: Disabled dependent information

Last name	First name	M.I.	Relationship

Date of birth (MM/DD/YYYY)	Social Security no.	Is the dependent currently married? ☐ Yes ☐ No

Address, if different from the above	City	State	ZIP code

Section 3: Has dependent ever been employed? – If yes, please complete this section.

Name of employer	Dates of employment (MM/YY) From	Through	Hours per week	Duties

Section 4: Medicare/Medicaid information

Is the above-named dependent receiving Medicaid/Medicare benefits? ☐ Yes ☐ No If yes, please provide information	Medicaid ID no.		Effective date
Medicare ID no.	Part A effective date	Part B effective date	Part D effective date

Section 5: Is disability due to accident or injury? – If yes, complete this section.

Where accident/injury occurred	Accident/injury date
How accident/injury occurred	

Section 6: Abilities and limitations

Describe in detail dependent's limitations in performing daily activities and ability to manage his/her own affairs.

Daily activities

Task performance

Social interaction

Section 7: Authorization and release of information

I hereby authorize any physician, other health care provider or facility that has diagnosed or rendered treatment for the above-named dependent to furnish Anthem Blue Cross and Blue Shield full information, including copies of medical records, relating to such diagnosis or treatment. I certify that the above statements are true and complete to the best of my knowledge and belief.

Employee signature **X**	Date

FOR PHYSICIAN USE ONLY: To be completed by treating physician

Examination – Date of last examination must be within one year to be considered.

Disabled dependent name (last, first, M.I.)	Date of first examination	Date of last examination

Diagnosis/Disability	Frequency of visits

Clinical information – Please complete this section or attach medical summary documenting all items listed.

Onset of disabling condition (MM/YYYY)	Tests/Data establishing diagnosis

Pertinent clinical findings and course (including recent lab data)

Other medical problems

Current medications

Treatment plan (include expected duration)

Is the dependent financially competent? ☐ Yes ☐ No

Is the dependent fully compliant with treatment? ☐ Yes ☐ No If not, please explain

Might the prognosis below be different if he/she were compliant? ☐ Yes ☐ No

Has the dependent been hospitalized for this disabling condition? ☐ Yes ☐ No If yes, please complete below

Facility	Dates
Facility	Dates

What is the nature and degree of the dependent's impairment in his/her capacities for:

Daily activities

Task performance

Social interaction

If disability involves developmental delay or intellectual deterioration, has IQ testing been performed? ☐ Yes ☐ No	Date performed

Results

Explain deficits in intellectual function (e.g. math, reading, comprehension, memory skills)

FOR PHYSICIAN USE ONLY: To be completed by treating physician *(Continued)*

Disabled dependent name (last, first, M.I.)

Is the dependent	☐ Ambulatory ☐ Bed confined	☐ Non ambulatory ☐ House confined	☐ Wheelchair confined ☐ Hospital/Institution confined – Facility name: _____

Is the dependent capable of supporting himself/herself through gainful employment? ☐ Yes ☐ No

Prognosis of totally disabling condition

☐ Permanent and total	☐ Permanent and partial _____%
☐ Temporarily disabled with expected return to partial function _____%	Return date
☐ Temporarily disabled with expected return to full function	Return date

If the disability is psychiatric, please complete this section (or address these items in your narrative report)

Complete DSMIV diagnosis required with descriptors, codes, and severity specifiers

Axis I		
Axis II		
Axis III		
Axis IV		
Axis V	GAF, current	
	GAF, highest, past year	

Physician's signature and information

I certify that the above statements relative to the disabled dependent named on this form are true and complete to the best of my knowledge and belief.

Physician signature **X**			Date
Physician's name			
Specialty		Phone no.	
Address	City	State	ZIP code