

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



1. I hereby apply for Anthem Blue Cross and Blue Shield coverage for my disabled _____
(Relationship)

<i>Dependent's last name</i>	<i>Dependent's first name</i>	<i>MI</i>	<i>Date of birth (MM/DD/YY)</i>
<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip code</i>
<i>Dependent's social security no.</i>	<i>Firm name</i>	<i>Firm number</i>	

2. If disability is due to accident or injury, how, when and where did it occur? _____

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

4. If the above-named dependent has ever been employed, indicate the name of the employer(s), dates of employment, and describe duties performed.

Name of Employer	Dates of Employment (M/Y)		Duties and number of hours per week
	From	Through	

5. Is the above-named dependent receiving Medicare benefits? Yes No
 If yes, include copy of Medicare Card or SSI Benefits with application.

6. Is the above-named dependent receiving Medicaid benefits? Yes No
 If yes, include copy of Medicaid Card with application.

7. Do you claim this dependent on your Federal Income Tax? Yes No

8. Does the dependent reside with the subscriber? Yes No
 If not, where does the dependent reside?

9. Is the dependent currently married? Yes No

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 _____ Date _____

Name (printed) _____ Anthem ID number _____

Address _____

The remainder of this form must be completed by the dependent's treating physician

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Disabled Dependent Child's Name: _____

THESE PAGES TO BE COMPLETED BY TREATING PHYSICIAN

Date of first examination: _____ Date of last examination: _____ Frequency of visits: _____
(must be within one year to consider this application)

Diagnosis/Disability *(include ICD9 Code - Required)* _____

Clinical Information

(Medical summary documenting all items listed can be attached to form in lieu of completing this section)

Onset of disabling condition (specify month and year) _____

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 compliant, how not? _____

If not, might the prognosis below be different if he/she were compliant?..... Yes No

Has the dependent been hospitalized for this disabling condition? Yes No

Dates and facility: _____

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 _____

Please specify deficits in intellectual function (e.g. math, reading, comprehension, memory skills)? _____

Disabled Dependent Child's Name: _____

Is the dependent Ambulatory Non Ambulatory Wheelchair Confined
 Bed Confined House Confined Hospital/Institution Confined – Facility Name _____

Is the dependent independently 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 also (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 yr: _____

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 _____ Date _____

Physician's name _____

Specialty _____

Address _____

Phone no. _____