Capital

# Disability Certification of Adult Dependents

| Office Use Only ____ ❑ Approve ❑ Reject T H I 2 | |
|---|---|
| Name | Date / / |

**PLEASE READ! IMPORTANT INFORMATION** THIS FORM MUST BE SIGNED BY THE ATTENDING PHYSICIAN (MD OR DO). SIGNATURES FROM OTHER PROVIDER TYPES WILL NOT BE ACCEPTED. MEDICAL RECORDS MUST BE SUBMITTED AND, IF APPLICABLE, SOCIAL SECURITY BENEFITS FORM. FAILURE TO FOLLOW THESE INSTRUCTIONS MAY RESULT IN A DENIAL OF COVERAGE.

Subscriber completes SECTION I and SECTION III (if applicable). Attending physician completes SECTION II.

## SECTION I—to be completed by the SUBSCRIBER

| Subscriber's name (Print last, first, middle initial) | Group number | Identification number |
|---|---|---|
| Address (number, street, city, state, and ZIP Code) | | |
| Full name of disabled dependent | Dependent's date of birth / / | Dependent's marital status ❑ Single ❑ Married |
| What is the relationship of the dependent to the subscriber? | | |
| Can dependent perform activities of daily living? (i.e., bathing, dressing, eating)? ❑ Yes ❑ No | | |
| Can dependent travel to and from a destination unattended? ❑ Yes ❑ No | | |
| What are the specific ways in which you support / assist the dependent? | | |
| At what age did the dependent's disability occur? | | |
| Why are you requesting benefits to continue? | | |
| Is the dependent currently employed, or has the dependent ever been employed in the past 12 months? ❑ Yes ❑ No **If "YES," give name(s) and address(es) of employer(s) and date(s) employed on reverse side of this form**. | | |
| Is the dependent now covered under any other hospital or medical coverage? ❑ Yes ❑ No **If "YES," furnish name of insurance company, group, or identification number**. | | |
| Is the dependent receiving Social Security Benefits? ❑ Yes ❑ No **If "YES", please provide the required documentation: effective date, copy of 'Notice of Award', and most recent notice of benefit changes.)** **Effective date** _____ | | |

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.**

**I hereby certify that the above child is unmarried, is incapable of self-support, is dependent upon me for more than half of his or her support and that his or her disability commenced prior to age 26.**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

| _____ | / / | ( ) _____ |
|---|---|---|
| Subscriber's signature | Date signed | Daytime telephone number |

Forward completed form and supporting documents to:
Enrollment & Billing, Capital Blue Cross, PO Box 772612, Harrisburg, PA 17177-2612 or Fax to 717.651.4922

## SECTION II—to be completed by ATTENDING PHYSICIAN (MD or DO only)

Any fee charged by the ATTENDING PHYSICIAN for the completion of this form is the responsibility of the subscriber.
(**MEDICAL RECORDS MUST BE SUBMITTED WITH THE COMPLETED FORM**)

Diagnosis and concurrent conditions resulting in disability:

If mentally impaired, it is required to define mental impairment in terms of Mental Age and/or IQ.

In addition to mental age and/or IQ please define functional capacity in work, educational, or social setting:

At what age did the disability begin to continually occur?

When did you first see this patient for this diagnosis?

What is the date you last saw this patient for the diagnosis?

Please include a brief outline of your patient's care plan including the frequency of visits and treatments prescribed.

Has this patient been compliant with recommendations for follow up? ❑ Yes ❑ No

How long do you anticipate the patient will be disabled? ❑ Less than 1 year ❑ 1 - 3 years ❑ Indefinitely (i.e., longer than 3 years)

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

| Name of physician (print or type) | Degree | Physician's signature | Date |
|---|---|---|---|
| | | | |

Address of physician (print or type)

## SECTION III—to be completed by the SUBSCRIBER (if applicable)

DEPENDENT'S EMPLOYMENT HISTORY (FOR THE PAST 12 MONTHS, BEGINNING WITH THE MOST RECENT)

| | | | |
|---|---|---|---|
| 1. Name of employer | Location | Dates<br>from: / /<br>to: / / | Hours worked per week |
| 2. Name of employer | Location | Dates<br>from: / /<br>to: / / | Hours worked per week |
| 3. Name of employer | Location | Dates<br>from: / /<br>to: / / | Hours worked per week |
| 4. Name of employer | Location | Dates<br>from: / /<br>to: / / | Hours worked per week |
| 5. Name of employer | Location | Dates<br>from: / /<br>to: / / | *Hours worked per week* |