

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



## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1040 tax filing attached					
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)		Hours per week	Duties
		From	Through		
		From	Through		
Section 4: Medicare/Medicaid information					
Is the above-named dependent receiving Medicaid/Medicare benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>X</b>				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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date performed
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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	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Non ambulatory	<input type="checkbox"/> Wheelchair confined
	<input type="checkbox"/> Bed confined	<input type="checkbox"/> House confined	<input type="checkbox"/> Hospital/Institution confined – Facility name: _____

Is the dependent capable of supporting himself/herself through gainful employment?  Yes  No**Prognosis of totally disabling condition**

<input type="checkbox"/> Permanent and total	<input type="checkbox"/> Permanent and partial _____%
<input type="checkbox"/> Temporarily disabled with expected return to partial function _____%	Return date 
<input type="checkbox"/> 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**

<b>Axis I</b>	
<b>Axis II</b>	
<b>Axis III</b>	
<b>Axis IV</b>	
<b>Axis V</b>	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 <b>X</b>	Date 		
Physician's name			
Specialty	Phone no.		
Address	City	State	ZIP code