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

Anthem BlueCross BlueShield

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 ☐ 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)		Hours per week	Duties
	From	Through		
	From	Through		

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

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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

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(711 :TDD/TTY)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahóót'i' t'áá ni nizaad k'ehji níká a'doowoł t'áá jiik'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.