



Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child

Instructions

1. Complete **Section I**.
2. Please give this form to the physician or psychologist who has firsthand knowledge of the child's condition.
3. Ask the physician or psychologist to complete and **personally** sign the **Section II** of this form.
4. Return the form to Member Underwriting at the address indicated on page 2.
5. If your child is not presently covered under your Blue Cross and Blue Shield membership, documentation from the child's current or previous insurance company verifying Disabled Dependent Status since age 19 and indicating termination date is required.

Section I (please print or type)

To Be Completed by the Subscriber

Subscriber's name: _____ BCBS ID No.: _____

Subscriber's address: _____ Type of Coverage: Individual Family

_____ Telephone No.: _____

If group coverage, employer's name: _____ Group no. (if known): _____

Child's name: _____ Child's date of birth: _____

Child's marital status: Single Individual Married

Does the child have his or her own Blue Cross Blue Shield membership? Yes No If yes, BCBS ID No.: _____

How long has this disability existed? Since birth Other (indicate approximate date of onset): _____

Is the child confined to an institution or attending school? Yes No

Date of admission: _____

Name and address of institution or school: _____

Is the child employed for wages? Yes No If yes, please indicate number of hours worked per week: _____

Date of employment: _____

Name and address of child's employer: _____

Is the child covered under the Federal Medicare Health Insurance program? Yes No

Medicare Category: Disabled Kidney Disease

If yes, please provide Medicare health insurance claim number: _____

Hospital Insurance (Part A) effective date: _____ Medical Insurance (Part B) effective date: _____

Is the child covered under Medicaid? Yes No

Is the child covered by any other insurance? Yes No If yes, please give name and address of insurance company: _____

Policyholder's name: _____

I attest that to the best of my knowledge and belief the information given above is correct. I understand that enrollment for this child under my coverage may remain in force only as long as the psychological or physical disability and dependency exists, and while my coverage is of the type which may include such a dependent child. I further understand that Blue Cross Blue Shield shall have the right to require recertification as to eligibility for continuation of dependency coverage from time to time, as often as Blue Cross Blue Shield may deem reasonable.

Signature of subscriber: _____ Date: _____

For Blue Cross Blue Shield Office Use Only

Approved for duration of condition or family policy

Approved on temporary basis Effective date: _____ Termination date: _____

Denied Reason: _____

Member Underwriting: _____

Date: _____ Ext. _____



Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child (cont.)

Section II (please print or type)

Patients Name: _____ Patient's Height: ft. _____ inches _____ Weight _____ lbs. _____

Diagnosis: _____

Severity: Mild Moderate Severe

To your knowledge, how long has this disability existed: Since birth Other (indicate date of onset)

Is the patient presently under treatment? Yes No

If yes, please describe nature of treatment: _____

Please describe the disability at the time of the patient's 19th birthday: _____

Physically disabled: _____

Psychologically disabled: _____

If the patient is mentally retarded, what is the mental age or I.Q.? MA _____ IQ _____

Prognosis: _____

Probable future course of treatment and duration: _____

In your professional opinion, is the patient capable of engaging in self-supporting employment? Yes No

If patient is employed, do you know what duties the patient's job requires? Yes No

If yes, please describe duties: _____

In your professional opinion, will this patient ever be capable of self-support? Yes No

If yes, please indicate when: _____

Remarks: _____

Physician and/or Psychologist Information

Signature of physician or psychologist: _____ Date: _____

Full Name of physician or psychologist: _____ Telephone Number: () _____

Office Address: _____

City _____ State _____ Zip _____

Please Mail To:

Blue Cross Blue Shield of Massachusetts
Member Underwriting Mail Stop 01/07
Landmark Center
401 Park Drive
Boston, MA 02215-3326

Due to patient confidentiality, this completed form may NOT be sent via FAX