

Disabled Dependent Review Process – Certification Form

(For Individual and Family Plans)

PLEASE READ CAREFULLY

To determine if your dependent qualifies for disabled dependent benefits past age 26, completion of this form by the policyholder and attending physician is required.

DIRECTIONS

- **1.** The policyholder must complete and sign the **Disabled Dependent Authorization** section.
- A licensed physician or mental health professional must complete and sign the Disabled Dependent Physician Certification section. Please complete the form in its entirety, as applicable. If more space is needed, use an additional sheet of paper or attach copies of medical records/progress notes.
- 3. Mail the completed form to:

Blue Cross and Blue Shield of Texas P.O. Box 660819 Dallas, TX 75266-0819

Or fax to: 800-279-7419

Upon completion of the review process, the policyholder and/or their employer group will receive a letter advising of the determination and coverage dates if applicable. Please allow up to 30 business days for review completion.

If you have questions, please contact customer service using the phone number on your medical insurance ID card.

BlueCross BlueShield of Texas

P.O. Box 660819, Dallas, TX 75266-0819 Fax: 800-279-7419

TO BE FILLED OUT BY THE POLICYHOLDER

1. NAME OF POLICYHOLDER (PRINT – LAST, FIRST & MIDDLE INITIAL)		1A. BLUE CROSS AND BLUE SHIELD OF TEXAS NUMBERS				
		GROUP	MEMBER ID			
		NUMBER	NUMBER			
2. POLICYHOLDER'S ADDRESS (NUMBER, STREET, CITY, STATE & ZIP CODE)						
3. DEPENDENT'S NAME 3A. DEPENDENT'S BIRTHDAT			3A. DEPENDENT'S BIRTHDATE (MM/DD/)	(YYY)		
			/ /			
3C. DEPENDENT'S RELATIONSHIP TO POLICYHOLDER 3D. DEP		ENDENT'S SEX	3E. DEPENDENT'S AGE WHEN			
		MALE FEMALE	DISABILITY OCCURRED			
4. IS DEPENDENT PERMANENTLY RESIDING IN YOUR HOU		12		T YES		
IF NO , PLEASE EXPLAIN. IF MORE SPACE IS NEEDED USE		-	2			
				🗌 NO		
5. IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT?		04		☐ YES ☐ NO		
IF YES , WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE? %						
5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?						
6. WAS DEPENDENT EVER EMPLOYED?						
				🗌 NO		
6A. IS DEPENDENT NOW EMPLOYED?						
				🗌 NO		
7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO						
REACHING AGE 26?						
				□ NO		
8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?						
9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?						
IF YES, PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER.						
INSURANCE COMPANY						
GROUP CERTIFICATE OR AGREEMENT NUMBER						
GROUP, CERTIFICATE OR AGREEMENT NUMBER						

When I provide an original or copy of this signed form, I am allowing any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide Blue Cross and Blue Shield of Texas (BCBSTX) with information. This may include copies of records concerning advice, care or treatment provided to the dependent named above, including, without limitation, information relating to mental illness, use of drugs or alcohol.

I understand that such information will be used by BCBSTX for the purpose of certifying the above named dependent as disabled for purpose of coverage under my health insurance. I understand that I or any other authorized representative will receive a copy of this authorization upon request. This authorization to collect medical information is valid from the date signed for a period of two and one-half years.

I certify that the above information is correct to the best of my knowledge and belief.

SIGNATURE OF POLICYHOLDER	DATE SIGNED

BlueCross BlueShield of Texas

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Disabled Dependent Physician Certification

TO BE FILLED OUT BY THE ATTEND		NOTE: Any fee for the comp	letion of this form is the responsibility of the policyholder.		
PATIENT NAME					
PHYSICIAN NAME		PHYSICIAN PHONE NUM	PHYSICIAN PHONE NUMBER		
PHYSICIAN ADDRESS					
DATE OF FIRST VISIT (MM/DD/YYYY) / /	FREQUENCY OF VISITS	LAST EXAM DATE (MM/D	D/YYYY) /		
NOTE: Please complete the form in its entir	ety, as applicable. If more space is needed	l, use an additional sheet of pa	aper or attach copies of medical records/progress notes.		
PRIMARY DIAGNOSIS (REQUIRED)					
PHYSICAL: ICD-10 CODES	BEHAVIORAL: ICD-10 CODES	DATE OF ONSET OF INC	APACITATING DIAGNOSIS (MM/DD/YYYY) /		
NATURE OF THE DISABILITY (REQUIRED)					
PLEASE DESCRIBE: ETIOLOGY/CAUSE, SEVERITY, C	URRENT SIGNS AND SYMPTOMS				
DAILY LIVING (REQUIRED)					
PLEASE GIVE DETAILS REGARDING: TYPICAL DAYS	SACTIVITY AND DEGREE OF ASSISTANCE	NEEDED TO COMPLETE THES	E ACTIVITIES		
PROVIDE SPECIFIC LIMITATIONS AND THE IMPAC	T THEY HAVE ON GAINFUL EMPLOYMENT				
WHEN DO YOU THINK THE PATIENT WILL BE ABL	E TO RETURN TO GAINFUL EMPLOYMENT	Γ?			
APPROXIMATE DATE: /	1	INDEFINITE N	IEVER		
FOR MENTAL DISABILITY (IF APPLICABLE)					
PHYSICAL & COGNITIVE LIMITATIONS			IQ TESTING RESULTS		
TREATMENT PLAN (REQUIRED)					
INCLUDE PREVIOUS, CURRENT, AND PLANNED TF	EATMENT; TREATMENT GOALS AND PRO	JECTED DURATION OF TREAT	MENT		
SECONDARY SUPPORTING DIAGNOSIS (IF APPL	ICABLE)				
CURRENT SIGNS AND SYMPTOMS SECONDARY TO	D THE DIAGNOSIS				
NAME OF PHYSICIAN (PRINT OR TYPE)			CREDENTIALS		

DATE SIGNED

PHYSICIAN'S SIGNATURE