



# 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.
2. 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.



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

TO BE FILLED OUT BY THE POLICYHOLDER

Form with 9 numbered sections for policyholder and dependent information, including fields for name, address, birthdate, sex, age, and household status.

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.

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

Signature and Date Signed fields



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TO BE FILLED OUT BY THE ATTENDING PHYSICIAN



NOTE: Any fee for the completion of this form is the responsibility of the policyholder.

Form section for patient and physician information including fields for Patient Name, Physician Name, Physician Phone Number, Physician Address, Date of First Visit, Frequency of Visits, and Last Exam Date.



NOTE: 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.

PRIMARY DIAGNOSIS (REQUIRED)

Form section for primary diagnosis with columns for Physical: ICD-10 Codes, Behavioral: ICD-10 Codes, and Date of Onset of Incapacitating Diagnosis.

NATURE OF THE DISABILITY (REQUIRED)

Text area for describing the nature of the disability, including etiology, cause, severity, current signs, and symptoms.

DAILY LIVING (REQUIRED)

Text area for providing details regarding typical day's activity and degree of assistance needed to complete these activities.

Text area for providing specific limitations and the impact they have on gainful employment.

Form section for return to gainful employment, including a question on when the patient will be able to return and checkboxes for indefinite or never.

FOR MENTAL DISABILITY (IF APPLICABLE)

Form section for mental disability with columns for Physical & Cognitive Limitations and IQ Testing Results.

TREATMENT PLAN (REQUIRED)

Text area for including previous, current, and planned treatment; treatment goals and projected duration of treatment.

SECONDARY SUPPORTING DIAGNOSIS (IF APPLICABLE)

Text area for describing current signs and symptoms secondary to the diagnosis.

Form section for physician information including fields for Name of Physician, Credentials, Physician's Signature, and Date Signed.