

# 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 – 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? <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"/> Bed confined	<input type="checkbox"/> Non ambulatory <input type="checkbox"/> House confined	<input type="checkbox"/> Wheelchair confined <input type="checkbox"/> Hospital/Institution confined – Facility name: _____
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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

# 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 مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة. (TTY/TDD: 711)

## Armenian

Ձեր 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 ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

#### Navajo

Bee ná ahoót'í t'áá ni nizaad k'ehji níká a'doowó t'áá jík'e. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí bé'esh bee hane'í bikáá' áá'j'í' hodiilnih. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí bé'esh bee hane'í bikáá' áá'j'í' hodiilnih. (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>.