

**DISABLED  
DEPENDENT  
CERTIFICATION**



**COMPLETE ALL ITEMS. *Incomplete forms will be returned, causing a delay in benefits.***

<b>SECTION 1: TO BE COMPLETED BY THE SUBSCRIBER</b>		
Subscriber's name (last, first, middle initial)	Group policy number	Subscriber's ID number
Subscriber's address (number, street, city, state, zip code)		
Full name of dependent child	Child's birth date	Child's marital status <input type="checkbox"/> Single <input type="checkbox"/> Married
Child's relationship to you	Child's sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Child's age when disability began:
Is the child dependent upon you for support? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," what part of support do you contribute?		
Was the child ever employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the child employed now? <input type="checkbox"/> Yes <input type="checkbox"/> No If either answer is "yes," list employer's name, address, and dates of employment:		
Monthly wages/earnings:		
Is the child now covered under any other hospital/medical/surgical/coverage other than Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," furnish name of insurance company and group or policy number:		
I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information requested with respect to this certification.		
Subscriber's signature: _____		Date: _____

**SECTION 2: DEPENDENT AUTHORIZATION**

*The dependent, or the person authorized to act on his or her behalf, is to complete the information requested in this section before giving this form to the physician for completion.*

I hereby authorize my attending physician \_\_\_\_\_ to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as the original. I understand that if I do not sign this authorization, or if I revoke or modify it, PacificSource Health Plans may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that PacificSource will keep confidential the information that is provider pursuant to this authorization and that it will be used solely to determine and act upon my request for this benefit.

\_\_\_\_\_  
Signature of dependent  
**OR**

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Person authorized to act on dependent's behalf

\_\_\_\_\_  
Relationship to dependent



PacificSource  
HEALTH PLANS

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Dear Physician:

This form will assist PacificSource Health Plans in processing the patient's claim for health insurance as a disabled dependent under his parent's or guardian's health plan. By providing the medical information requested promptly and legibly, you will help the patient expedite the claims process.

**Please send the completed forms to:**

Health Services Department  
PacificSource Health Plans  
PO Box 7068  
Eugene, OR 97401-3667

**SECTION 3: MEDICAL REPORT  
TO BE COMPLETED BY THE ATTENDING PHYSICIAN**  
*Please DO NOT send information copied directly from the patient's medical record at this time.*

**Dates pertaining to this condition:**  
I attended patient for the current disabling medical problem or condition from \_\_\_\_\_ to \_\_\_\_\_ (dates);  
At intervals of \_\_\_\_\_. I last examined the patient on \_\_\_\_\_ (date).  
Date of disability onset:

**Diagnosis (required):**

ICD-9 Disease Code, Primary (required): \_\_\_\_\_ ICD-9 Disease Code(s), Secondary: \_\_\_\_\_

DSM IV Code(s), if any: \_\_\_\_\_

**Statement of symptoms and clinical findings:**

**Current treatment(s) and/or medication(s)** rendered to the patient for this disability:  
  
 The patient is not currently receiving treatments or medications for this disability.

**Functional Assessment of Activities of Daily Living (ADLs):** Indicate the patient's degree of physical and mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. A ten (10) indicates the patient is completely disabled in the ADL skill or ability. These functional disabilities limit the patient's capacity for self-support.

Mobility Skills	Self-care Skills	Sensory Skills	Cognitive Skills
___ walking	___ feeding	___ hearing	___ judgment
___ sitting	___ bathing	___ seeing	___ memory
___ standing	___ toileting	___ speech	___ planning/follow through
___ lifting	___ dressing	___ touch	___ thinking/processing information
___ bending			

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**Psychological/Psychiatric Assessment:** List the specific psychological/psychiatric symptoms and behaviors (if any) that affect the patient's ADLs and limit his or her capacity to be self-supporting.

**For purposes of this benefit, a PacificSource Health Plans member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e. not capable of engaging in any substantial gainful employment) due to physical or mental disability.**

*Oregon residents only:*

Did the disability begin prior to the child reaching 23 years of age and exist continuously to the present?  Yes  No

*Idaho residents only:*

Did the disability begin prior to the child reaching 21 years of age (or 25 years of age if the child is a full-time student—six credit hours, if disabled) and exist continuously to the present?  Yes  No

Based on your examination, does this patient currently have a physically or mentally disabling injury, illness, or condition?

No, the patient does not have a physically or mentally disabling injury, illness, or condition.

Yes. (Please answer the next question.)

In your medical or psychiatric opinion, please select **A**, **B**, or **C**:

**A.** The patient's current disability DOES NOT render him or her incapable of self-support.

**B.** The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by (projected date) \_\_\_\_\_. *Please make some estimate, including month and year, of when the condition is likely to improve or resolve.*

**C.** The patient's current disability is of permanent or extended duration and, consequently, the patient is not and will not be capable of self-support within the foreseeable future (e.g., more than five years).

I certify that, based on my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self-support, and that I am a \_\_\_\_\_ (specialty) licensed to practice in the state of \_\_\_\_\_.

Physician's name as shown on license

Original signature of attending physician

Physician's address (number, street, city, state, ZIP code)

Telephone number

Date

**SECTION 4: PACIFICSOURCE HEALTH PLANS USE ONLY**

This claim was reviewed by \_\_\_\_\_ on \_\_\_\_\_ (date)

**Claim approved** for enrollment through \_\_\_\_\_ (date)

**Claim denied**