PacificSource HEALTH PLANS

Disabled Dependent Certification

Complete all items. Incomplete forms will be returned, causing a delay in benefits.

Section 1: To be completed by the parent or guardian

Your name _____

Group policy number _____ Your PacificSource ID number _____

Your address _____

City _____ State _____ Zip _____

Full name of dependent child _____ Child's sex: ☐ Male ☐ Female

Child's birth date _____ Child's relationship to you _____

Child's age when disability began _____ Child's marital status: ☐ Single ☐ Married

Is the child dependent upon you for support? ☐ Yes ☐ No If "yes," what part of support do you contribute? _____

Was the child ever employed? ☐ Yes ☐ No Is the child employed now? ☐ Yes ☐ 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? ☐ Yes ☐ No

If "yes," furnish name of insurance company _____

Insurance 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.

Your 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 provided pursuant to this authorization and that it will be used solely to determine and act upon my request for this benefit.

Signature of dependent _____ Date signed _____

OR

Person authorized to act on dependent's behalf _____ Relationship _____

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
Springfield, OR 97475-0068

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-10 Disease Code, Primary (required) _____ ICD-10 Disease Code(s), Secondary _____

DSM V 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			

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 _____

City _____ State _____ Zip _____

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**