BlueCross BlueShield
of Western New York

Disability Certification

To be completed by *subscriber*

Failure to complete the entire questionnaire may cause a delay in eligibility qualification.

Dependent Name: _____

Date of Birth: _____

Identification #: _____

Group #: _____

Reference #: _____

Regardless of their current age, unmarried children may be eligible for continued dependent coverage under their parent's plan if they are covered as dependent children under their parent's health benefits (or before reaching age 26 in the absence of such coverage) if they are incapable of self-sustaining employment due to:

- Mental illness/developmental disability (as defined by NYS Mental Hygiene Law), or
- Physical disability

In order to determine your child's eligibility for continued coverage, please provide the information requested on this form. The reverse side should be completed and certified by your child's physician. Please return to our plan in the enclosed envelope when completed.

1. Is dependent a full time student? Yes ☐ No ☐

   If NO, indicate last grade completed: _____

   Please also indicate any special programs that have been completed.

   _____

2. Name of school: _____ Grade: _____

3. Has dependent been employed full or part-time since his/her 26th birthday? Yes ☐ No ☐

   If YES, provide employer name, address, phone number, and dates of employment:

Name	Address	Phone	Dates

4. Is dependent receiving Medicare? Yes ☐ No ☐

   If YES, please provide information from dependent's Medicare ID card:

   Hospital insurance (Part A) effective date: _____

   Medical insurance (Part B) effective date: _____

   Medicare claim number: _____

Print subscriber name: _____

Subscriber signature: _____ Date: _____

To be completed by *physician*

Failure to complete the entire questionnaire may cause a delay in eligibility qualification.

Patient's name: _____ Date of birth: _____

Patient's diagnosis: _____

Type of disability (please check): ☐ Developmental disability ☐ Mental illness ☐ Physical disability

History Date symptoms first appeared or accident happened: _____

Present condition

1. At what age level does the patient function: _____
2. Patient's IQ: _____
3. Degree of physical impairment: ☐ None ☐ Mild ☐ Severe
4. Degree of psychiatric impairment: ☐ None ☐ Mild ☐ Severe
5. Has the disability existed continuously since patient's 26th birthday? ☐ Yes ☐ No
6. Is patient capable of self-support? ☐ Yes ☐ No
7. Is patient capable of attending school? ☐ Yes ☐ No
8. Is patient: ☐ Ambulatory ☐ Bed confined ☐ House or hospital confined
9. Can patient use public transportation? ☐ Yes ☐ No

Treatment

1. Date of last visit (must be within the last 12 months): _____
2. Current treatment status including mental status and physical exam:

   _____
3. Is patient involved currently in a therapy program? ☐ Yes ☐ No
4. List hospitalizations, if any:

   Name: _____ Dates: _____

   Name: _____ Dates: _____

Prognosis

1. Will the patient make any significant physical or mental progress with continued therapies that would improve his or her functional status? ☐ Yes ☐ No
2. Please estimate period patient will remain totally disabled. Date: _____

I certify that this patient is disabled as stated in this questionnaire.

Print physician's name: _____

Physician's signature: _____ Date: _____

Address: _____

_____

Phone: _____