Blue Cross Blue Shield of Massachusetts
Member Underwriting Mail Stop 01-07
Landmark Center
401 Park Drive
Boston, MA 02215-3326

Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child

Due to patient confidentiality, this completed form may NOT be sent via FAX

Instructions:

1. Complete **Section I**
2. Please give this form to the physician or psychologist who has firsthand knowledge of the child's condition
3. Ask the physician or psychologist to complete and **personally** sign the **Section II** of this form
4. Return the form to Member Underwriting at the address indicated above.
5. **If child is not presently covered under your BCBSMA membership, please provide us with documentation verifying the child's continuous enrollment as a dependent under your health plan(s) from the date the child would have lost coverage as a dependent had he or she not been disabled. We may accept, for example, documentation from an insurance company or third party that administered your previous health plan or from an employer that sponsored your previous health plan.**

Section I (please print or type)

To Be Completed by the Subscriber

Enter your name and identification number as they appear on your BCBSMA identification card.

Subscriber's name: _____ BCBSMA ID No.: _____

Subscriber's address: _____ Type of Coverage: ☐ **Individual** ☐ **Family**

_____ Telephone No.: (_____) _____

If group coverage, employer's name: _____ Group No. (if known): _____

Child's name: _____ Child's date of birth: _____/_____/_____

Child's martial status: ☐ **Single** ☐ **Married**

Does the child have his or her BCBSMA membership? ☐ **Yes** BCBSMA ID No.: _____ ☐ **No**

How long has this disability existed: ☐ **Since birth** ☐ **Other** (indicate approximate date of onset): _____

Is the child confined to an institution or attending school?

☐ **Yes** Date of admission _____

Name and address of institution or school: _____

☐ **No**

Is the child employed for wages?

☐ **Yes** Date of employment _____ Number of hours worked per week: _____

Name and address of child's employer: _____

☐ **No**

Is the child covered under the Federal Medicare Health Insurance program?

☐ **Yes** Medicare Category: ☐ **Disabled** ☐ **Kidney Disease**

Medicare Health Insurance Claim number: _____

Hospital Insurance (Part A) effective date: _____ Medical Insurance (Part B) effective date: _____

☐ **No**

Is child covered under Medicaid? ☐ **Yes** ☐ **No**

Is the child covered by any other insurance?

☐ **Yes** Name and address of insurance company: _____

Policyholder's name: _____

☐ **No**

I attest that to the best of my knowledge and belief the information given above is correct. I understand that enrollment for this child under my coverage may remain in force only as long as the psychological or physical disability and dependency exists, and while my coverage is of the type which may include such a dependent child. I further understand that BCBS shall have the right to require recertification as to eligibility for continuation of dependency coverage from time to time as often as BCBS may deem reasonable.

Signature of Subscriber: _____ Date: _____

For Blue Cross Blue Shield Massachusetts Office Use Only

☐ **Approved** for duration of condition or family policy

☐ **Approved on temporary basis** Effective date: _____ Termination date: _____

☐ **Denied** Reason: _____

Member Underwriting: _____ **Date:** _____ **Ext.** _____

Section II (please print or type)

To Be Completed by the Child's Attending Physician and/or Psychologist

Patient's Name: _____ Patient's Height: _____ ft. _____ inches Weight: _____ lbs.

Diagnosis: _____

_____
(print or type)

Severity: ☐ Mild ☐ Moderate ☐ Severe

To your knowledge, how long has this disability existed? ☐ Since birth ☐ Other (indicate date of onset) _____

Is the patient presently under treatment?

☐ Yes, describe the nature of the treatment: _____
(print or type)

_____

☐ No

Please describe the disability at the time of the patient's 19th birthday:

Physically disabled: _____
(print or type)

_____

Psychologically disabled _____
(print or type)

_____

If the patient is mentally retarded, what is the mental age or I.Q.? M.A. _____ I.Q. _____

Prognosis: _____
(print or type)

Probable future course of treatment and duration: _____
(print or type)

_____

In your professional opinion, is the patient capable of engaging in self-supporting employment? ☐ Yes ☐ No

If patient is employed, do you know what duties the patient's job requires?

☐ Yes, describe duties: _____

☐ No

In your professional opinion, will this patient ever be capable of self-support?

☐ Yes, indicate when: _____

☐ No

Remarks: _____
(print or type)

_____

_____

Physician and/or Psychologist Information

Signature of licensed Physician or Psychologist: _____ Date _____

Full Name of licensed Physician or Psychologist: _____ Tel. No.: (_____) _____
(print or type)

Office Address: _____

City: _____ State: _____ Zip: _____

PLEASE MAIL TO:

Blue Cross Blue Shield of Massachusetts
Member Underwriting Mail Stop 01-07
Landmark Center
401 Park Drive
Boston, MA 02215-3326

Due to patient confidentiality, this completed form may NOT be sent via FAX