



Blue Cross Blue Shield of Massachusetts
 Member Underwriting Mail Stop 02-03
 One Enterprise Drive
 QuincyMa 02171-2125

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 marital 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 26th birthday:

Physically disabled: _____
(print or type)

Psychologically disabled _____
(print or type)

If the patient is developmentally delayed, 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: _____

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