Capital BLUE

Disabled Dependent Certification Form

Office Use Only ____ ❑ Approve ❑ Reject
T H I 2
Name Date / /

Subscriber completes SECTION I and SECTION III (if applicable). Attending physician completes SECTION II.

SECTION I—to be completed by the SUBSCRIBER

Subscriber's name (Print Last, First, Middle Initial)	Group number	Identification number
Address (number, street, city, state, and ZIP Code)		
Full name of disabled dependent	Dependent's date of birth / /	Dependent's marital status ❑ Single ❑ Married
What is the relationship of the dependent to the subscriber? ❑ Son ❑ Daughter		
At what age did the dependent's disability occur?		
Is the dependent residing in your household? **If "NO", explain:**	❑ Yes ❑ No	
Does the dependent rely upon you for support?	❑ Yes ❑ No	
Do you claim him/her as a dependent on the federal income tax form?	❑ Yes ❑ No	
Is the dependent currently employed, or has the dependent ever been employed in the past 12 months? **If "YES", give name(s) and address(es) of employer(s) and date(s) employed on reverse side of this form.**	❑ Yes ❑ No	
Is dependent now covered under any other hospital or medical coverage? **If "YES", furnish name of insurance company, group, or identification number.**	❑ Yes ❑ No	
Is the dependent covered under Medicare? **If "YES", please send a copy of the Medicare card.**	❑ Yes ❑ No	

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 signed / / _____ Daytime telephone number ( )

SECTION II—to be completed by ATTENDING PHYSICIAN (MD or DO only)

Any fee charged by the ATTENDING PHYSICIAN for the completion of this form is the responsibility of the subscriber.
(Be sure to submit supporting documentation when returning the completed form.)

Diagnosis
When did you first see this patient for this diagnosis?
How long has this patient been under your care?
At what age did the disability begin to continually occur?
Explain how this disability makes the patient incapable of self-support:
How long do you anticipate the disability will continue? ❑ Less than 1 year ❑ 1 - 3 years ❑ Indefinitely (i.e., longer than 3 years)
Please explain how the illness/exacerbations interfere with gainful employment.

Name of Physician (print or type) _____ Degree _____ Physician's Signature _____ Date / /

Address of Physician (print or type) _____

Forward completed form and supporting documents to:
Account Administration, Capital BlueCross, PO Box 772612, Harrisburg, PA 17177-2612

SECTION III—to be completed by the SUBSCRIBER (if applicable)

DEPENDENT'S EMPLOYMENT HISTORY (FOR THE PAST 12 MONTHS, BEGINNING WITH THE MOST RECENT)

1. Name of Employer	Location	Dates from: / / to: / /	Hours Worked Per Week
2. Name of Employer	Location	Dates from: / / to: / /	Hours Worked Per Week
3. Name of Employer	Location	Dates from: / / to: / /	Hours Worked Per Week
4. Name of Employer	Location	Dates from: / / to: / /	Hours Worked Per Week
5. Name of Employer	Location	Dates from: / / to: / /	Hours Worked Per Week