BlueCross BlueShield of Montana

Disabled Dependent Review Process – Certification Form

PLEASE READ CAREFULLY

To determine if your dependent qualifies for disabled dependent benefits past age 26, completion of this form by the policyholder and attending physician is required.

DIRECTIONS

1. The policyholder must complete and sign the **Disabled Dependent Authorization** section.
2. A licensed physician or mental health professional must complete and sign the **Disabled Dependent Physician Certification** section. Please complete the form in its entirety, as applicable. If more space is needed, use an additional sheet of paper or attach copies of medical records/progress notes.
3. Submit the completed form to Blue Cross and Blue Shield of Montana using one of the following methods:
   - **Mail**:
     Blue Cross and Blue Shield of Montana
     PO Box 660255
     Dallas, TX 75266-0255
   - **Fax:**
     312-729-2490
   - **Upload:**
     Sign into your Blue Access for Members℠ account, click on Messages, upload the form and send to Membership Maintenance. For assistance in BAM℠, please call the number on the back of your ID card.

Upon completion of the review process, the policyholder and/or their employer group will receive a letter advising of the determination and coverage dates if applicable. Please allow up to 30 business days for review completion.

If you have questions, please contact customer service using the phone number on your medical insurance ID card.

BlueCross BlueShield of Montana

PO Box 660255, Dallas, TX 75266-0255
Fax: 312-729-2490

Disabled Dependent Authorization

TO BE FILLED OUT BY THE POLICYHOLDER

1. NAME OF POLICYHOLDER (PRINT – LAST, FIRST & MIDDLE INITIAL)	1A. BLUE CROSS AND BLUE SHIELD OF MONTANA NUMBERS GROUP NUMBER MEMBER ID NUMBER	
2. POLICYHOLDER'S ADDRESS (NUMBER, STREET, CITY, STATE & ZIP CODE)		
3. DEPENDENT'S NAME		3A. DEPENDENT'S BIRTHDATE (MM/DD/YYYY) / /
3C. DEPENDENT'S RELATIONSHIP TO POLICYHOLDER	3D. DEPENDENT'S SEX ☐ MALE ☐ FEMALE	3E. DEPENDENT'S AGE WHEN DISABILITY OCCURRED

4. IS DEPENDENT PERMANENTLY RESIDING IN YOUR HOUSEHOLD? IF **NO**, PLEASE EXPLAIN. IF MORE SPACE IS NEEDED USE AN ADDITIONAL SHEET OF PAPER.	☐ YES ☐ NO
5. IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT? IF **YES**, WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE? %	☐ YES ☐ NO
5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?	☐ YES ☐ NO
6. WAS DEPENDENT EVER EMPLOYED?	☐ YES ☐ NO
6A. IS DEPENDENT NOW EMPLOYED?	☐ YES ☐ NO
7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO REACHING AGE 26?	☐ YES ☐ NO
8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?	☐ YES ☐ NO
9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE? IF **YES**, PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER. INSURANCE COMPANY GROUP, CERTIFICATE OR AGREEMENT NUMBER	☐ YES ☐ NO

When I provide an original or copy of this signed form, I am allowing any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide Blue Cross and Blue Shield of Montana with information. This may include copies of records concerning advice, care or treatment provided to the dependent named above, including, without limitation, information relating to mental illness, use of drugs or alcohol.

I understand that such information will be used by BCBSMT for the purpose of certifying the above named dependent as disabled for purpose of coverage under my health insurance. I understand that I or any other authorized representative will receive a copy of this authorization upon request. This authorization to collect medical information is valid from the date signed for a period of twenty-four months.

I certify that the above information is correct to the best of my knowledge and belief.

SIGNATURE OF POLICYHOLDER	DATE SIGNED

359675.1224

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Disabled Dependent Physician Certification

TO BE FILLED OUT BY THE ATTENDING PHYSICIAN

NOTE: Any fee for the completion of this form is the responsibility of the policyholder.

PATIENT NAME		
PHYSICIAN NAME		PHYSICIAN PHONE NUMBER
PHYSICIAN ADDRESS		
DATE OF FIRST VISIT (MM/DD/YYYY) / /	FREQUENCY OF VISITS	LAST EXAM DATE (MM/DD/YYYY) / /

NOTE: Please complete the form in its entirety, as applicable. If more space is needed, use an additional sheet of paper or attach copies of medical records/progress notes.

PRIMARY DIAGNOSIS (REQUIRED)		
PHYSICAL: ICD-10 CODES	BEHAVIORAL: ICD-10 CODES	DATE OF ONSET OF INCAPACITATING DIAGNOSIS (MM/DD/YYYY) / /

NATURE OF THE DISABILITY (REQUIRED)

PLEASE DESCRIBE: ETIOLOGY/CAUSE, SEVERITY, CURRENT SIGNS AND SYMPTOMS

DAILY LIVING (REQUIRED)

PLEASE GIVE DETAILS REGARDING: TYPICAL DAY'S ACTIVITY AND DEGREE OF ASSISTANCE NEEDED TO COMPLETE THESE ACTIVITIES

PROVIDE SPECIFIC LIMITATIONS AND THE IMPACT THEY HAVE ON GAINFUL EMPLOYMENT

WHEN DO YOU THINK THE PATIENT WILL BE ABLE TO RETURN TO GAINFUL EMPLOYMENT?

APPROXIMATE DATE: ____ / ____ / ____ ☐ INDEFINITE ☐ NEVER

FOR MENTAL DISABILITY (IF APPLICABLE)	
PHYSICAL & COGNITIVE LIMITATIONS	IQ TESTING RESULTS

TREATMENT PLAN (REQUIRED)

INCLUDE PREVIOUS, CURRENT, AND PLANNED TREATMENT; TREATMENT GOALS AND PROJECTED DURATION OF TREATMENT

SECONDARY SUPPORTING DIAGNOSIS (IF APPLICABLE)

CURRENT SIGNS AND SYMPTOMS SECONDARY TO THE DIAGNOSIS

NAME OF PHYSICIAN (PRINT OR TYPE)	CREDENTIALS
PHYSICIAN'S SIGNATURE	DATE SIGNED