BlueCross BlueShield of Montana

P.O. Box 4309, Helena, MT 59604

Date _____

DEPENDENT CHILD'S STATEMENT OF DISABILITY

Group No. _____ Identification No. _____

Employee's Name _____

Employee's Street Address _____

City _____ State _____ ZIP Code _____

Dependent Child's Name _____

Social Security No. _____ Relationship _____

Dependent Child's Place of Residence/Street Address _____

City _____ State _____ ZIP Code _____

Marital Status _____ Date of Birth _____

I hereby authorize any hospital, physician or health care provider who has treated the above dependent child to furnish medical information that is specific to the dependent's disability to Blue Cross and Blue Shield of Montana and HMO Montana®. This authorization will expire one year after the employee's signature date.

Employee's Signature _____ Date _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

NOTE: ANY FEE FOR THE COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE PATIENT.

1. Patient's Name _____
2. Diagnosis (Be as detailed as possible) _____
3. If dependent child has ever been under observation, care or treatment related to the dependent's disability in any hospital, sanitarium, asylum or similar institution, please complete the following:
   Name of hospital or institution _____
   Number of days _____ Date of last treatment or care _____
4. Treatment (a) Date of first visit _____
   (b) Frequency of visits Weekly ☐ Monthly ☐ Other ☐ _____
5. Extent of Disability
   (a) Is patient now incapable of self-support because of disability? Yes ☐ No ☐
   (b) Disability has existed continuously since _____
   (c) When do you think patient will be able to return to gainful employment?
   Approximate Date _____ Indefinite ☐ Never ☐

Physician's Name _____ Phone _____

Physician's Street Address _____

City _____ State _____ ZIP Code _____

Physician's Signature _____ Date _____