po box 1407, church street station
new york, ny. 10008-1407

_____
_____
Identification Number

Dear Member:

This will confirm that your health plan covers mentally challenged or physically handicapped overage dependents provided the child:

•became mentally challenged, developmentally disabled, mentally ill or physically handicapped before reaching the contract age limit for dependent children.

•has not married, and

•is incapable of self-sustaining employment, due to the severity of the disabling condition. (NOTE: The inability to find employment or a reduction in work capability does not constitute evidence of eligibility.)

When a mentally challenged or physically handicapped child over the contract age is eligible as a dependent under family coverage, all related benefits, terms and conditions will apply.

Please provide six months of office notes and a letter from the treating physician that demonstrates objective, documented physical dysfunction which prevents any form of self sustaining employment and how accommodation is not possible. A Social Security Income (SSI) determination, with work history that is current (within 12 months) is also required. This should include vocational or occupational evaluation by a certified provider.

Lastly, have the form provided with this letter fully completed and returned to us so we may take the necessary action.

Sincerely,

Membership & Billing

PLEASE READ THIS LETTER PRIOR TO FILLING OUT THE DISABLED DEPENDENT FORM.

REQUEST FOR OVERAGE DEPENDENT COVERAGE

For unmarried dependent child OVER the dependent age limit in the contract who is mentally challenged, developmentally disabled, mentally ill or physically handicapped prior to his or her ineligible date of coverage with Empire BlueCross.
The criterion for determining handicapped status is whether the child is capable of being employed and that the condition started while the child was an eligible dependent under the plan. Please have your provider submit documentation that will substantiate the ability or lack of ability of your dependent to work. Examples of documentation are educational and psychological test results, medical tests and functional capacity test results, vocational rehabilitative services records, doctors' notes and hospital records. Empire will review the records and make a determination as to whether your dependent qualifies.

INSTRUCTIONS:

CONTRACT HOLDER – Please complete Section I and include supporting documentation
ATTENDING PHYSICIAN – Please complete Section II of this form
RETURN FORM TO: Empire BlueCross, PO Box 1407 Church Street Station NY, NY 10008-1407

Note: THIS REQUEST FORM WILL NOT BE ACCEPTED UNLESS ALL SECTIONS ARE COMPLETED WITH SUPPORTING DOCUMENTS

SECTION I – TO BE COMPLETED BY CONTRACT HOLDER

NAME OF CONTRACT HOLDER	ADDRESS OF CONTRACT HOLDER (NO. & STREET, CITY, STATE, ZIP CODE, APT. NO)			
NAME OF DEPENDENT CHILD	SEX ☐ M ☐ F	ID NUMBER OF DEPENDENT CHILD	DEPENDENT'S DOB MON DAY YEAR	DEPENDENT'S MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED
ADDRESS OF DEPENDENT CHILD (NO.& STREET, CITY, STATE, ZIP CODE, APT. NO)			MEMBER ID NUMBER	GROUP NUMBER
WAS DEPENDENT CHILD EVER INSTITUTIONALIZED ☐ YES ☐ NO	IF YES, GIVE NAME & ADDRESS OF INSTITUTION(S) AND PERIOD OF CONFINEMENT			
IS DEPENDENT ELIGIBLE FOR CARE UNDER FEDERAL, STATE, LOCAL LAW, MEDICARE? ☐ YES ☐ NO	IF YES, GIVE DETAILS		EFFECTIVE DATE OF MEDICARE ELIGIBILITY: PART A PART B	
WAS OR IS DEPENDENT EMPLOYED FOR WAGES: ☐ YES ☐ NO DATES OF LAST EMPLOYMENT FROM: TO:	NAME AND ADDRESS OF CURRENT OR LAST EMPLOYER		IS DEPENDENT A FULL TIME STUDENT ☐ YES ☐ NO	
SCHOOL ATTEND(ED)(ING)	DATE FROM: TO:	IS DEPENDENT ON MEDICAL LEAVE FROM SCHOOL: ☐ YES ☐ NO DATE OF START OF LEAVE:		
DOES DEPENDENT PLAN TO RETURN TO SCHOOL: ☐ YES ☐ NO RETURN TO SCHOOL DATE:	SIGNATURE OF PARENT OR GUARDIAN		DATE SIGNED	

SECTION II – TO BE COMPLETED BY PHYSICIAN

IS DEPENDENT PRESENTLY INCAPABLE OF SELF SUSTAINING EMPLOYMENT BY REASON OF: ☐ MENTAL ILLNESS ☐ MENTAL RETARDATION ☐ DEVELOPMENTALLY DISABLED ☐ PHYSICAL HANDICAP	WHAT DATE DID THE INCAPACITY BEGIN:	WAS CONDITION THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO DATE OF ACCIDENT:

DIAGNOSIS: Dependent's IQ if applicable:

CLINICAL FINDINGS/SEVERITY OF ILLNESS:

FUNCTIONAL STATUS:

CURRENT TREATMENT:

PLEASE ATTACH SUPPORTING DOCUMENTATION

IN YOUR OPINION WILL THIS CHILD EVER BE CAPABLE OF SELF-SUSTAINING EMPLOYMENT? ☐ YES ☐ NO ☐ NOT AT THIS TIME

SIGNATURE OF ATTENDING M.D.	SPECIALTY	ADDRESS	DATE SIGNED:

FOR OFFICIAL USE ONLY

☐ PERMANENT APPROVAL ☐ TEMPORARY APPROVAL (ONE YEAR) ☐ DENIAL	☐ SIGNATURE OF MEDICAL DIRECTOR	DATE SIGNED