

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.
- 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 Illinois using one of the following methods:
 - Mail:

Blue Cross and Blue Shield of Illinois PO Box 660603 Dallas, TX 75266-0603

- 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.

Group-Disabled Dependent Certification-2024



PO Box 660603 Dallas, TX 75266-0603 Fax: 312-729-2490

TO BE FILLED OUT BY THE POLICYHOLDER

GROUP MEMBER ID NUMBER NUMBER 2. POLICYHOLDER'S ADDRESS (NUMBER, STREET, CITY, STATE & ZIP CODE) 34. DEPENDENT'S BIRTHDATE (MMODDRYYN) 2. DEPENDENT'S NAME 34. DEPENDENT'S BIRTHDATE (MMODDRYYN) 2. OLEPENDENT'S RELATIONSHIP TO POLICYHOLDER 30. DEPENDENT'S SEX 3E. DEPENDENT'S AGE WHEN 3C. DEPENDENT PERMANENTLY RESIDING IN YOUR HOUSEHOLD? 3E. DEPENDENT'S AGE WHEN USABILITY OCCURRED 4. IS DEPENDENT PERMANENTLY RESIDING IN YOUR HOUSEHOLD? USE NO 5. IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT? % NO 6. IS DEPENDENT LISTED AS A DEPENDENT DO YOU CONTRIBUTE? % NO 6. WAS DEPENDENT EVER EMPLOYED? NO NO 6. WAS DEPENDENT REVER EMPLOYED? YES 7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO YES 8. IS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO NO 7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO YES 8. IS DEPENDENT NOW COVERED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)? YES 9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE? NO 9. IS DEPENDENT NOW COVERED UNDER MEDICARE O	1. NAME OF POLICYHOLDER (PRINT – LAST, FIRST & MIDDLE INITIAL)		1A. BLUE CROSS AND BLUE SHIELD OF ILLINOIS NUMBERS						
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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 Illinois 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 BCBSIL 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 two and one-half years.

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

SIGNATURE OF POLICYHOLDER	DATE SIGNED



PO Box 660603 Dallas, TX 75266-0603 Fax: 312-729-2490

TO BE FILLED OUT BY THE ATTENDING PHYSICIAN

Disabled Dependent Physician Certification

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

PATIENT NAME							
PHYSICIAN NAME			PHYSICIAN PHONE NUMBER				
PHYSICIAN ADDRESS			I				
DATE OF FIRST VISIT (MM/DD/YYYY) FREQU		FREQUENCY OF VISITS		LAST EXAM DATE (MM/DD/YYYY) / /			
NOTE: Please complete the form in its entire	ty, as app	licable. If more space is needed,	use an additional sheet	of paper or attach co	opies of medical records/progress notes.		
PRIMARY DIAGNOSIS (REQUIRED)							
PHYSICAL: ICD-10 CODES	HYSICAL: ICD-10 CODES BEHAVIORAL: ICD-10 CODES			F INCAPACITATING E /	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 RETU	IRN TO GAINFUL EMPLOYMENT					
APPROXIMATE DATE: /		/		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)			CREDENTIAL	CREDENTIALS			
PHYSICIAN'S SIGNATURE			DATE SIGNE	DATE SIGNED			