

# 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<sup>™</sup> account, click on Messages, upload the form and send to Membership Maintenance. For assistance in BAM<sup>™</sup>, 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						
3. DEPENDENT'S NAME       3A. DEPENDENT'S BIRTHDATE (MMMDDY'YY)         3. CEPENDENT'S RELATIONSHIP TO POLICYHOLDER       3D. DEPENDENT'S SEX         3. DEPENDENT'S RELATIONSHIP TO POLICYHOLDER       3E. DEPENDENT'S AGE WHEN         4. IS DEPENDENT PERMANENTLY RESIDING IN YOUR HOUSEHOLD?       IF NO, PLEASE EXPLAIN. IF MORE SPACE IS NEEDED USE AN ADDITIONAL SHEET OF PAPER.         5. IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT?       IF YES, WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE?       NO         5. A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?       IVES         6. WAS DEPENDENT EVER EMPLOYED?       YES         NO       NO         6. WAS DEPENDENT EVER EMPLOYED?       IVES         NO       NO         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       IVES         8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       IVES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       IVES         9. IS DEPENDENT NOW COVERE									
3C. DEPENDENT'S RELATIONSHIP TO POLICYHOLDER       3D. DEPENDENT'S SEX       3E. DEPENDENT'S AGE WHEN	2. POLICYHOLDER'S ADDRESS (NUMBER, STREET, CITY, STATE & ZIP CODE)								
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3C. DEPENDENT'S RELATIONSHIP TO POLICYHOLDER       3D. DEPENDENT'S SEX       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.       \$\$\  \Creater S \  \Creater	3. DEPENDENT'S NAME			3A. DEPENDENT'S BIRTHDATE (MM/DD/YYYY)					
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Imale       Disability occurred         Is DEPENDENT PERMANENTLY RESIDING IN YOUR HOUSEHOLD?       YES         IF NO, PLEASE EXPLAIN. IF MORE SPACE IS NEEDED USE AN ADDITIONAL SHEET OF PAPER.       NO         S.       IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT?       YES         IF YES, WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE?       %       NO         SA. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?       YES         NO	3C. DEPENDENT'S RELATIONSHIP TO POLICYHOLDER	3D. DEPE	ENDENT'S SEX	35. DEPENDENT'S AGE WHEN					
IF NO, PLEASE EXPLAIN. IF MORE SPACE IS NEEDED USE AN ADDITIONAL SHEET OF PAPER.       NO         5. IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT?       YES         IF YES, WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE?       %         5. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?       YES         6. WAS DEPENDENT EVER EMPLOYED?       YES         6. IS DEPENDENT NOW EMPLOYED?       YES         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       YES         8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         9. NO       IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         9. NO       IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES		□ M.	IALE 🔲 FEMALE						
Instruction       Instruction         5. IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT?       YES         IF YES, WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE?       NO         5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?       YES         IN 00       IN 00         6. WAS DEPENDENT EVER EMPLOYED?       YES         IN 00       NO         6A. IS DEPENDENT NOW EMPLOYED?       YES         IN 00       NO         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       YES         IN 00       NO         8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       YES         IN 00       NO         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         IF YES, PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER.       YES									
IF YES, WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE?       NO         5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?       YES         NO       YES         NO       YES         6. WAS DEPENDENT EVER EMPLOYED?       YES         6A. IS DEPENDENT NOW EMPLOYED?       YES         NO       YES         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       YES         NO       NO         8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         IF YES, PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER.       YES	IF <b>NO</b> , PLEASE EXPLAIN. IF MORE SPACE IS NEEDED USE	AN ADE	DITIONAL SHEET OF PAPER	<i></i>	□ NO				
IF YES, WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE?       NO         5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?       YES         NO       YES         NO       YES         6. WAS DEPENDENT EVER EMPLOYED?       YES         6A. IS DEPENDENT NOW EMPLOYED?       YES         NO       YES         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       YES         NO       NO         8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         IF YES, PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER.       YES									
IF YES, WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE?       NO         5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?       YES         NO       YES         NO       YES         6. WAS DEPENDENT EVER EMPLOYED?       YES         6A. IS DEPENDENT NOW EMPLOYED?       YES         NO       YES         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       YES         NO       NO         8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         IF YES, PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER.       YES									
5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?       YES         6. WAS DEPENDENT EVER EMPLOYED?       YES         6A. IS DEPENDENT NOW EMPLOYED?       YES         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       YES         8. IS DEPENDENT COVERED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES					U YES				
Image: Second	IF <b>YES</b> , WHAT PERCENTAGE OF SUPPORT DO YOU CONTR	RIBUTE?	%		□ NO				
6. WAS DEPENDENT EVER EMPLOYED?       YES         6. NO       YES         6. IS DEPENDENT NOW EMPLOYED?       YES         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       YES         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       YES         8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES	5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST	FEDERAI	L INCOME TAX RETURN?						
A. IS DEPENDENT NOW EMPLOYED?       Implicit Now         6A. IS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       Implicit Now         7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO       Implicit Now         8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       Implicit Now         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       Implicit Now         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       Implicit YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       Implicit YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       Implicit YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       Implicit YES         9. NO       Implicit NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER.       Implicit YES									
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REACHING AGE 26?       NO         8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?       YES         9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       YES         IF YES, PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER.       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.									
9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE?       □ YES         IF YES, PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER.       □ NO	8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?								
IF <b>YES</b> , PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER.									
INSURANCE COMPANY									
GROUP, CERTIFICATE OR AGREEMENT NUMBER									

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) / /			
<b>NOTE:</b> 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			