DELTA DENTAL
Northeast Delta Dental

HealthTrust

Anthem

An independent licensee of the Blue Cross and Blue Shield Association.
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P.O. BOX 617, CONCORD, NEW HAMPSHIRE 03302-0617
800.527.5001 • OUTSIDE NH 888.254.9869 • FAX 603.226.2988 • WWW.HEALTHTRUSTONLINE.ORG

Request for Certification for a Mentally or Physically Incapacitated Dependent Child

Important: If you are transferring from another insurance carrier and the child is over nineteen years of age written documentation is required from your prior carrier which states that:

- Dependent child was covered on a continual basis
- Coverage was in effect up to the date of insured's HealthTrust coverage.

Section 1 – Subscriber and Dependent Child Information:

Name of Subscriber:	Street Address:	City:	State / Zip:
Subscriber's Identification Number:	Name of Employer:	Group Number:	
Name of Dependent Child to be Covered:	Street Address if Different:	City:	State / Zip:
Dependent Child's Birth Date: Month Day Year	Dependent Child's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		

Is the Dependent Child employed for wages? ☐ No ☐ Yes
If yes, give name of employer and approximate number of hours worked per week:
Employer Name:_____ Number of Hours Worked: _____

Is the Dependent Child confined to an institution or attending school? ☐ No ☐ Yes
If yes, give name of institution or school and date of admission:
Name of Institution or School: _____ Date of Admission: _____

Is the above-named dependent receiving Medicare benefits? ☐ No ☐ Yes
If yes, include copy of Medicare card or SSI benefits with application.

Is the above-named dependent receiving Medicaid benefits? ☐ No ☐ Yes
If yes, include copy of Medicaid card with application.

Has the Dependent Child applied for SSI benefits? ☐ No ☐ Yes Date of Application: _____

What is the length of time this disability has existed? _____ Start Date: _____

Section 2 – Parent or Legal Guardian Signature:

I am requesting that the above-mentioned Child be included under my HealthTrust membership. I understand that this Child may be covered under my membership only so long as:

- The Child is incapable of self-support because of a physical or mental incapacity which existed prior to age nineteen (19), and
- I furnish more than one-half of this Child's support.

I further understand that:

- It is the responsibility of the applicant to notify HealthTrust of any change in the status of the dependent's incapacity, and that
- Anthem Blue Cross and Blue Shield/HealthTrust shall have the right to require recertification as to the eligibility for continuation of coverage as an incapacitated dependent.

If you have additional questions or need assistance in completing this form, please contact your group's Benefits Administrator or the Customer Service number listed on your Anthem BCBS ID card.

The information I have supplied above is true, and to the best of my knowledge, correct.

I hereby authorize any physician, other health care provider or facility that has diagnosed or rendered treatment for the above-named dependent to furnish Anthem Blue Cross and Blue Shield, full information, including copies of medical records, relating to such diagnsosis or treatment. I certify that the above statements are true and complete to the best of my knowledge and belief.

Subscriber Signature: _____ Date: _____

Before you return the application, have you:

☐ Completed and verified all information and sections of this application?
☐ Read and signed section 2?
☐ Read and understood all sections?
☐ Submitted this form to the Dependent Child's Attending Physician for completion and signature:
☐ If Dependent Child is over 19 years of age and your are transferring from another insurance carrier, have you supplied written documentation of prior coverage up to the effective date of HealthTrust coverage?

Please return form to: HealthTrust, P.O. Box 617, Concord, NH 03302-0617. **Questions?** Call the Customer Service number of your ID card.

Section 3 – Child's Attending Physician Certification (TO BE COMPLETED BY PHYSICIAN):

Date of First Examination: ____ /____ /____ Date of Last Examination: ____ /____ /____ Frequency of Visits: _____

(must be within one year to consider this application)

Diagnosis/Disability (include ICD9 Code – *required*): _____

Clinical Information:
Medical summary documenting all items listed can be attached to form in lieu of completing this section.

Onset (specify date): ____ /____ /____

Test/Data Establishing Diagnosis: _____

_____

_____

Pertinent Clinical Findings and Course (including recent lab data): _____

_____

_____

Other Medical Problems: _____

Current Medications: _____

Treatment Plan (include expected duration): _____

_____

_____

If the disability is psychiatric, please complete this section also (or address these items in your narrative report).

Complete DSMTV *diagnosis required with descriptors, codes, and severity specifiers:* Axis I Axis II Axis III Axis IV Axis V GAF, current: GAF, highest, past year	Is the dependent financially competent? ☐ No ☐ Yes Is the dependent fully compliant with treatment? ☐ No ☐ Yes If non-compliant, how not? _____ If not, might the prognosis be different if he/she were compliant? ☐ No ☐ Yes Has the dependent been hospitalized for a psychiatric condition? Dates and facility: _____ What is the nature and degree of the dependent's impairment in his/her capacities for: daily activities? _____ task performances? _____ social interaction? _____

If disability involves developmental delay or intellectual deterioration, has IQ testing been performed? ☐ No ☐ Yes
Results: _____ Date performed: _____

If not, what intellectual functions can be performed (e.g., math, reading, comprehension, memory skills): _____

Is the dependent: ☐ Ambulatory ☐ Non-ambulatory ☐ Bed Confined ☐ Wheelchair Confined ☐ House Confined
☐ Hospital/Institution Confined – Facility Name: _____

Is the dependent independently capable of supporting himself/herself through gainful employment? ☐ No ☐ Yes

Prognosis of Totally Disabling Condition:
☐ Permanent and Total ☐ Permanent and Partial (%)
☐ Temporarily Disabled with Expected Return to Partial Function (%) *Return* Date: _____
☐ Temporarily Disabled with Expected Return to Full Function (5) *Return* Date: _____

I certify that the above statements are relative to the disabled dependent named on the reverse side are true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

Physician's Name: _____

Physician's Specialty: _____

Physician's Address: _____

_____

License Number: _____

Do not write in this space – office use only