BlueCross BlueShield of Oklahoma

Office Use Only
Form Received on:_____

☐ Permanent Approval ☐ Denied
☐ Temporary Approval
Recertify by:_____ (date)
Need additional: _____
By: _____
Medical Director Signature Date

Request to Extend Coverage for Disabled Dependent

This form is used to request an extension of health coverage for your unmarried dependent child who is mentally or physically disabled and unable to earn a living. This form is used both for the initial request as well as periodic evaluations that may be required.

SECTION 1 (TO BE COMPLETED BY MEMBER)

ALL QUESTIONS MUST BE ANSWERED

MEMBER INFORMATION

Member's Name *(First, MI, Last):*		**Employer:**	
Member's Address *(City, State, Zip)*:			
Member's Phone Number: Work	Home	Other	
Health Plan Group Number:	**Member ID:**	**Member Gender** ☐ M ☐ F	**Member DOB:**

DEPENDENT INFORMATION

Dependent's Legal Name *(First, MI, Last):*		**Dependent's Relationship to Employee:**
Dependent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner		
Dependent's Gender: ☐ M ☐ F	**Dependent's Date of Birth:**	**Dependent's SSN:**
Dependent's Address *(City, State, Zip):*		
Nature of Disability:	Does disability prevent dependent from being able to work? ☐ Yes ☐ No	
Does dependent permanently reside in employee's household? ☐ Yes ☐ No If **no**, please explain:		
Is this individual dependent upon you for support? ☐ Yes ☐ No	If **yes**, what percent support do you contribute?	
Is this individual listed as a dependent on your last Federal Income Tax Return? ☐ Yes ☐ No	Is dependent receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)? ☐ Yes ☐ No If **yes**, provide copy of award letter and most recent monthly statement.	
Is dependent employed? ☐ Yes ☐ No	Has dependent ever been employed? ☐ Yes ☐ No	
Is dependent covered by Medicaid? ☐ Yes ☐ No or Medicare: ☐ Yes ☐ No	Medicaid Number: Effective Date: Medicare Number: Part A Effective Date: Part B Effective Date:	
If dependent has ever been under observation, care or treatment in any hospital, sanitarium, or similar institution, please complete the following: **Name of hospital or institution:**		
Date of last treatment or care:	Number of days:	

I certify that the above named disabled dependent lives with me or his/her care is provided by me and I am responsible for his/her care and support. I also certify that the statements made above are true and complete to the best of my knowledge.

I understand that such information will be used by Blue Cross and Blue Shield for the purpose of certifying the above name dependent as disabled for the 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.

I understand that continued coverage for this disabled dependent is not guaranteed and is subject to approval by the Blue Cross and Blue Shield Medical Director. I understand that any fraudulent statements may be cause for termination from this program.

_____ _____
Member Signature Date Signed

SECTION 2 (TO BE COMPLETED BY ATTENDING PHYSICIAN)

ALL QUESTIONS MUST BE ANSWERED

Required: ***ATTACH CURRENT MEDICAL RECORDS – REQUEST WILL NOT BE PROCESSED WITHOUT MEDICAL RECORDS.***

Please note: Any fees for the completion of this form or copies of medical records are solely the responsibility of the member.

Patient's (Dependent's) Name:

1. Nature and cause of disability. (Provide complete diagnosis. You may attach a narrative summary relative to diagnosis/prognosis.)

2. Is the patient incapable of self-sustaining employment due to this physical or mental disability? ☐ Yes ☐ No

3. Will the patient be capable of employment in the future?

☐ Yes ☐ No ☐ Questionable If **yes**, supply:

Type of work dependent will be capable of performing:

Number of work hours per week:

Approximate date returning to work:

4. How does this condition(s) restrict/limit the patient's ability to engage in normal activities?

5. Has this disability been diagnosed as permanent? ☐ Yes ☐ No If **no**, how long will this condition last?

6. Is the patient currently incapable of self-support because of disability? ☐ Yes ☐ No

7. Estimate when patient will be capable of self-support: Approximate Date: ☐ Never

8. Date/age of onset of disability:

9. Date of patient's last examination:

10. Disability has been continuous since (date)**:**

11. Treatment frequency: Date of first visit: Frequency: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other _____

Attending Physician's Name:

Address (city, state, zip)**:**

Phone Number:

Additional Comments:

****** PLEASE INCLUDE COPIES OF CURRENT MEDICAL RECORDS ******

Physician's Signature:

Date Signed: