MASSACHUSETTS

REQUEST FOR RETAINING COVERAGE FOR A DISABLED ADULT DEPENDENT

To verify your dependent's eligibility as a disabled adult dependent, please:

1. Complete **Section I**.
2. Give this form to the doctor or provider who is most familiar with your child and their condition. Ask the doctor or provider to complete and **personally** sign **Section II**.
3. Mail the form, with all sections completed, to:
   Blue Cross Blue Shield of Massachusetts
   Member Underwriting
   One Enterprise Drive
   Quincy, MA 02171-2125

Important Information: If this dependent isn't currently covered under your Blue Cross Blue Shield of Massachusetts health plan, we need documentation verifying their continuous enrollment as a dependent under your health plan(s) from the date they would have lost coverage as a dependent without a disability, such as documentation from an insurance company remove completely.

Section I: To Be Completed by the Subscriber

Subscriber Information: Provide the information as it appears on your Blue Cross member ID card.

Name:		**Type of Coverage:** ☐ Individual ☐ Family
Subscriber ID Number:		
Subscriber Address:		
City:	**State:**	**ZIP:**
Phone:	**Email:**	
If group coverage, employer's name:	**Group Number (if known):**	

Dependent Information

Name:	**Date of Birth:** ___/___/____	**Marital Status:** ☐ Single ☐ Married ☐ Divorced
Relationship to Subscriber:	**Address:**	
City:	**State:**	**ZIP:**
Medical Condition:		

Do they have their own Blue Cross membership?
☐ No ☐ Yes. Member ID Number:

How long has their disability existed?
☐ Since birth ☐ Other. Please provide approximate date of onset:

Do they attend school or a residential program?
☐ No ☐ Yes. Date of admission: ___/__/____

Name of school or program:
Address:
City: **State:** **ZIP:**

Are they employed for wages?
☐ No ☐ Yes.
Start date: ___/___/_____

Number of hours worked per week:

Name of employer:
Address:
City: **State:** **ZIP:**

(Continued)

Dependent Information (continued)

Are they covered under Medicare?	Category:	Claim Number:	Hospital Insurance (Part A) effective date:
❑ No ❑ Yes	❑ Disabled ❑ Kidney disease		Medical Insurance (Part B) effective date:

Are they covered by any other insurance?	Name and address of insurance company:	Policyholder's name:
❑ No ❑ Yes		

I attest that to the best of my knowledge and belief the above information is correct. I understand that my dependent child may only be enrolled under my coverage as long as their disability and dependency exist, and the type of coverage I have may include such a dependent. I further understand that Blue Cross Blue Shield of Massachusetts has the right to require recertification of eligibility for continuation of dependency coverage from time to time.

Subscriber Signature:	Date:

Section II: To Be Completed by the Doctor or Provider

Please attach all relevant medical documentation that supports the disability diagnosis, including: office notes, specialist consultations, progress reports, and treatment plans.

Patient's Name:

Diagnosis:	Severity: ❑ Mild ❑ Moderate ❑ Severe ❑ Profound

To your knowledge, how long has this disability existed? ❑ Since birth ❑ Other. Please provide approximate date of onset:

Is the patient presently under treatment?
❑ No ❑ Yes. Describe the nature of the treatment:

Describe the disability at the time of the patient's 26th birthday:

Physical disability:	Psychological disability:

If the patient is developmentally delayed, what is their mental age or I.Q.?

Mental age: I.Q.: Prognosis: Probable future course of treatment and duration:

In your professional opinion, is the patient capable of engaging in self-supporting employment? ❑ No ❑ Yes

If patient is employed, do you know what duties the patient's job requires? ❑ No ❑ Yes. Describe duties:

In your professional opinion, will this patient ever be capable of self-support? ❑ No ❑ Yes. Indicate when:

Remarks:

Physician Information

Signature:	Date:

Name:	Practice Name:	Phone:

Practice Address:

City:	State:	ZIP: