Population Health Services

Application to Request Continuation of Coverage for a Disabled Dependent Child

Please submit this form with all supporting documentation to WellSpan Population Health Services Customer Service Department: P.O. Box 2347, York, PA 17405 • (717) 851-6800 or (800) 842-1768 or fax to: (717) 755-7190

_____**Initial Request** _____**Re-certification**

PART A – TO BE COMPLETED BY EMPLOYEE (Please Print Clearly or Type)

Employee (Subscriber) name:	Family ID#: xxxxxxxxx
Employer:	
Dependent's name:	Daytime telephone #:
Dependent's date of birth: mm / dd / yy	Dependent's SSN: xxx - xx - xxxx
Dependent's address/telephone number:	
Relationship to Employee: ☐ Biological child ☐ Adopted child ☐ Guardianship ☐ Stepchild	Dependent is: ☐ Single ☐ Married ☐ Divorced
Was Dependent ever employed? ☐ Yes ☐ No	Is Dependent currently employed? ☐ Yes ☐ No
If you answered "yes" to either of the above questions, give name(s) and address(es) of employer(s) and date(s) employed:	
Was this Dependent claimed as a "dependent" on the employee's Federal Income Tax filing for the prior year? ☐ Yes ☐ No	**Will** this Dependent be claimed as a "dependent" on the employee's Federal Income Tax filing for this year? ☐ Yes ☐ No
Has anyone else claimed this Dependent for Federal Income Tax purposes? ☐ Yes ☐ No If "yes," who?	
Is this Dependent covered under any other health plan? ☐ Medicare ☐ Medicaid ☐ Employer-sponsored health plan ☐ Other (explain):_____	
If so, please provide the name, address, and identification number of the other plan(s):	
Note: If you have not already done so, it may be to your financial advantage to contact Social Security and apply for Social Security payments and/or Medicare Health Insurance or Supplemental Security Income (SS) and/or Medicaid on behalf of your disabled dependent.	
Nature of Dependent's disability:	
Age when disability occurred:	Does this disability prevent the Dependent from being able to work? ☐ Yes ☐ No
Name, address, and telephone number of the primary (or attending) physician:	
Names(s), address(es), and telephone number(s) of any other specialist or treating physician:	
Statement of Authorized Representative (Part C) and Attending Physician's Statement (Part D) must be completed and returned with this application.	

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PART B – EMPLOYEE CERTIFICATION

I certify that the above-named dependent child lives with me or his/her care is provided by me, and I am responsible for his/her support. I also certify that the statements made above are true and complete to the best of my knowledge. I understand that continued coverage for this disabled dependent after the limiting age, as stated in my Plan, is not guaranteed and is subject to approval by the Plan. I understand that any fraudulent statements may be cause for discontinued participation for my disabled dependent under the Plan.

Signature:_____

Print your name:_____ Date:_____

PART C – STATEMENT OF AUTHORIZED REPRESENTATIVE

To be completed by the Dependent

If you wish to give authority to another party to file an Application to Continue Coverage for a Disabled Dependent Child on your behalf for enrollment, or continued enrollment, on the employee's health plan as a "disabled dependent," please complete the following information. If you wish this person to receive Protected Health Information (PHI) regarding your medical history and care, you must check the appropriate box(es) below and you and your Authorized Representative must both sign and date this form.

Your Name:_____ Daytime telephone #:_____

Address:

I hereby authorize the person named below to represent me for my eligibility as a "disabled dependent" with the Plan based on both my medical and financial status.

I understand that this authorization is voluntary and, if I choose to do so, I have the right to revoke it, in writing, to the Plan and to my designated representative. The Plan and my designated representative will no longer use or disclose my PHI, except to the extent the Plan or my designated representative has taken action in reliance upon this authorization. I also understand that the Plan will, at all times, comply with all federal and state regulations regarding the privacy of my PHI.

Name of Authorized Representative_____Daytime telephone #:_____

Address of Authorized Representative:_____

☐ I authorize the Plan to disclose Protected Health Information regarding my medical condition and care and/or payment information to the above named individual. This information must be relevant to the request filed with the Plan on mm / dd / yy (date of request).

The above authorization may include the following medical records and types of information, if box(es) are checked: ☐ Mental health treatment ☐ HIV/AIDs-related treatment or testing ☐ Substance abuse treatment

☐ This authorization shall become effective immediately and shall remain in effect until the earlier of final resolution of my request or mm / dd / yy (specify date).

Your signature:_____

Print your name: Date:

To be completed by Authorized Representative

I am authorized to sign this authorization on behalf of _____ (name of dependent) and on the basis of:

☐ Legal Authority (Power of Attorney, etc.)
☐ Parent, Guardian, or other individual acting in loco parentis

Signature of Authorized Representative:_____

Print your name:_____ Date:_____

WELLSPAN HEALTH

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PART D – TO BE COMPLETED BY ATTENDING PHYSICIAN

The following information is needed in connection with an application for continued health plan coverage for a "disabled dependent." Please provide your full reply and describe the nature and severity of the disability or impairment. Your prompt completion of this form will expedite the disability application process. Any fee for completion of this form and other information is the responsibility of the applicant or employee.

Please include all medical records along with the following information:

1. Dependent (patient) name:_____
2. Diagnosis of disability:_____
3. List any other diagnoses for this patient:_____

_____

4. Estimate of the expected date of full or partial recovery:_____
5. Severity of disability: ☐ Mild ☐ Moderate ☐ Severe
6. Please attach a narrative (on your letterhead) addressing the following points:

   - The history of the specific medical condition(s), including reference to findings from previous examinations, treatment, and responses to treatment.
   - Clinical findings from your most recent medical evaluation, including findings of physical examinations, results of laboratory tests, x-rays, etc., and other special evaluations or diagnostic procedures and, in the case of psychiatric disease, the findings of mental status examinations and the results of psychological tests.
   - Assessment of the current clinical status and plans for future treatment.
   - Assessment of the degree to which the medical condition has or has not become static, well stabilized, or controlled, and an explanation of the medical basis for this conclusion.
   - Specify the physical and/or mental limitations or restrictions caused by the patient's medical/mental condition(s).
   - Does the patient's condition preclude or limit self-supporting employment? Explain your answer.
   - If the patient is incapable of self-support, at what age did the patient become incapable?
   - Can the patient handle his or her own finances?

Physician name (print):_____

Degree:_____ Specialty Board Certification:_____

Physician signature:_____ Date:_____

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