

REQUEST TO EXTEND LIMITING AGE FOR DEPENDENT CHILD

To the Policyholder:
 Your schedule of benefits allows coverage for a dependent child beyond the limiting age if the child meets the definition of an incapacitated dependent as defined by BlueChoice HealthPlan policy.
 An incapacitated dependent is defined as an unmarried child who is incapable of performing gainful employment or attending school due to congenital disability, illness (including mental), physical injury or intellectual deficiency, which began before the child reached the limiting age. Additionally, the child must be dependent upon the policyholder for at least 51 percent of his/her support.
 The information requested on this form aids in providing BlueChoice HealthPlan the necessary information to make a coverage determination.

SECTION 1 – TO BE COMPLETED BY POLICYHOLDER

Policyholder's Name:		Member ID #:	Group #:	Name of Group:
Policyholder's Address (number, street, city, state and ZIP code):				
Dependent's Name:		With whom does Dependent live?	Relationship of Dependent to Policyholder:	
Dependent's Address (if not residing with Policyholder):				
Please explain why Dependent doesn't live with Policyholder:				
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Birthdate: (Month/Day/Year)	Is Dependent married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of onset of Dependent's condition:	
Is Dependent intellectually challenged? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				
Is Dependent mentally ill? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				
Is Dependent physically challenged or has special needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				
Is Dependent able to: Ambulate? <input type="checkbox"/> Yes <input type="checkbox"/> No		Speak? <input type="checkbox"/> Yes <input type="checkbox"/> No	Feed self? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bathe self? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dress self? <input type="checkbox"/> Yes <input type="checkbox"/> No	Be left alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the Policyholder contribute a minimum of 51% to the total support of the Dependent?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is Dependent incapable of self-sustaining employment?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has Dependent ever been employed? If yes, please give:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Last date of employment: _____		Type of work: _____	Average number of hours worked per week: _____	
Is Dependent currently employed? If yes, please describe:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of work: _____		Average number of hours worked per week: _____		
Is Dependent able to attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the Dependent currently attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, how many hours/day? _____ how many days/week? _____				
If the Dependent is not currently attending school, has the Dependent ever attended school? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, what was the highest grade level completed? _____				
At what age and/or grade level does the Dependent currently function? _____				
Please attach documentation such as school records or court orders of disability or incapacitation and/or any other pertinent information which describes the Dependent's condition.				
I CERTIFY THAT INFORMATION PROVIDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY WITH RESPECT TO THIS COVERAGE EXTENSION REQUEST.				
Name of Policyholder (Please print)		Signature of Policyholder		Date

SECTION 2 – TO BE COMPLETED BY ATTENDING PHYSICIAN

Patient's Name:
Diagnosis of condition causing incapacity (Please give as much detail as possible. Attach additional pages as necessary.)
Diagnosis:
Clinical description to support incapacity:
Objective findings (current signs, result of pertinent diagnosis studies):
Nature of treatment (including surgery, therapy, medications, etc.):
Is the patient intellectually impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please note IQ or other standardized intellectual screening result: <input type="checkbox"/> None (IQ 85 and above) <input type="checkbox"/> Borderline (IQ 71–84) <input type="checkbox"/> Mild (IQ 50–70) <input type="checkbox"/> Moderate (IQ 35–49) <input type="checkbox"/> Severe/Profound (IQ 34 and below)
Remarks:
Is patient mentally ill? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: (Include reason mental illness prevents the patient from gainful employment or attending school.)
REMARKS AND SUGGESTIONS: (Other medical conditions and any other information that would enable us to make a determination of the Dependent's incapacity.)

Please attach documentation of pertinent medical records, if necessary.

Attending Physician's Name (please print):	Attending Physician's Phone Number:
Attending Physician's Address:	Attending Physician's Signature/Date:

For BlueChoice HealthPlan use only:	
Incapacitated Minor determination: <input type="checkbox"/> Approve <input type="checkbox"/> Deny If denial, reason: _____	
BlueChoice HealthPlan Medical Director: _____	Date: _____
Eligibility updated by: _____	Date: _____
Letter sent by: _____	Date: _____