BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Incapacitated Dependent Certification

Blue Cross and Blue Shield of Alabama
Attention: Customer Accounts
450 Riverchase Parkway East
PO Box 995
Birmingham, Alabama 35298-0001

Subscriber: Please read the conditions of eligibility below, complete this form and sign it. Then, ask your dependent's physician to complete, sign and mail the completed form to the address above, right.

CONDITIONS OF ELIGIBILITY FOR AN INCAPACITATED DEPENDENT OVER THE AGE LIMIT IN YOUR CONTRACT PLAN

Subject to provisions in the subscriber's Contract or Plan, an incapacitated dependent will be considered for coverage to any age provided the dependent

- is unmarried,
- is mentally or physically disabled or incapacitated,
- is so incapacitated as to be incapable of self-sustaining employment,
- is dependent upon the subscriber for support and maintenance and lives with the subscriber in a regular parent-child relationship,
- and the condition must have occurred prior to the dependent's attaining 26 years of age or the age as specified in the subscriber's Contract or Plan.

Neither a reduction in work capacity nor inability to find employment are, of themselves, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated. To apply for eligibility for a dependent under this provision, this form must be certified by the subscriber and the dependent's attending physician and submitted to Blue Cross and Blue Shield of Alabama 60 days in advance of the effective date of extension of coverage.

EMPLOYEE / APPLICANT *(Please type or print)*

Dependent Child's Name *(Last, First, Initial)*	Child's Sex ☐ Male ☐ Female	Child's Birthdate MM / DD / YYYY

Dependent Child's Social Security Number	Relationship to Employee/Applicant

Employee's / Applicant's Name *(Last, First, Initial)*	Contract Number	Group Number (if shown on ID Card)	Name of Employee's/Applicant's Employer

Employee's / Applicant's Street Address, City, State and ZIP

Child's marital status ☐ Single ☐ Widowed ☐ Married ☐ Divorced	Date child's disability occurred	Is child permanently residing in your household? ☐ Yes ☐ No *(explain):*

Is child dependent on you for support? ☐ Yes ☐ No	If "Yes" what part of support do you contribute? *(% of total)*	Was child taken as a dependent on your last income tax return? ☐ Yes ☐ No	Was child ever employed? ☐ Yes ☐ No

Is child employed? ☐ Yes ☐ No	If answer to either of the last two questions is "Yes': give name(s), address(es) of employer(s) and date(s) employed

Is dependent eligible for any other care under federal, state or local law? ☐ Yes ☐ No	Do you, your spouse, or the dependent have other health care coverage? ☐ Yes ☐ No

If "Yes" give name and address of other insurance company

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge. I hereby authorize any physician or other person who has attended my above named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him to Blue Cross and Blue Shield of Alabama. Any charges for providing this information will be my responsibility.
I understand that enrollment for this child under my coverage may remain in force so long as this dependency exists and while my coverage is of the type which may include such a dependent child. I further understand that Blue Cross shall have the right to require recertification as to eligibility for continuation of dependency coverage as often as Blue Cross may reasonably require.

Signature of Subscriber	Date	Contract Number

PHYSICIAN'S QUESTIONNAIRE — This section is to be completed by dependent child's attending physician.

1. On what date did the dependent's disability occur?

 ______ MM ______ DD ______ YYYY

2. Describe the nature of the dependent's disability and give a brief assessment of his/her prognosis.

3. Has the dependent's disability existed continuously up to the present?

 ☐ **YES**
 ☐ **NO**

4. Do you consider the disability to be permanent?

 ☐ **YES**
 ☐ **NO**; I estimate the length of disability at ______________ ☐ months / ☐ years

5. Is the dependent able to perform the basic activities of daily living; i.e., independent feeding, dressing, performing personal hygiene, and grooming?

 ☐ **YES**
 ☐ **NO**

6. Is the dependent capable of managing toilet activities?

 ☐ **YES**
 ☐ **NO**

7. Does the dependent suffer with a ***severe organic psychiatric disease*** which results in one or more of the following: (Please check those descriptions which are applicable and comment if necessary)

 ☐ Unmanageable hallucinations, loss of touch with reality, paranoia, and/or other severe dysfunctional behaviors

 ☐ Repeated destructive behavior towards self, others, and/or property.

 ☐ Severe impairment of mobility with physical and/or mental inability to use adaptive equipment, such as walkers, crutches, wheelchairs, etc.

 ☐ Chronic and/or long-term disease or injury, impairing ability to work or attend school during the recuperative period of the disease or injury.

 ☐ Severe or profound mental retardation as defined by confirmed I.Q. test scoring. ***(List below the results of the most recent I.Q. testing.)***

Your comments:

PLEASE ATTACH A COPY OF YOUR MORE RECENT MEDICAL RECORDS FOR THIS PATIENT.

Physician's Street Address, City, State, ZIP	**Physician's Signature**	**Date Signed**

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Authorization for Disclosure of Protected Health Information

This authorization will permit Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of your Health Plan to disclose your health information that you describe below ("Protected Health Information") to the persons or entities and for the purpose that you describe below. **Please read and complete the following, and return to Blue Cross and Blue Shield of Alabama, PO Box 10485, Birmingham, Alabama 35202-0485.**

A. The Individual Who is The Subject of The Protected Health Information.

Note: A separate authorization form must be completed by each individual (or his/her personal representative) who desires to request that Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of his/her Health Plan disclose his/her Protected Health Information as described in this authorization.

Name:		Contract Number: (as it appears on your Health Plan ID Card)	Social Security Number:
Address:		Date of Birth: (MMDDYYYY)	Telephone Number:

B. Description of My Protected Health Information To Be Disclosed.

Note: Please insert your initials in front of the paragraph below (1, 2, 3 or 4) that applies to the description of your Protected Health Information to be disclosed pursuant to this authorization. If you initial paragraph 2, 3 or 4 please complete additional details requested.

1. _______	**Any or all of my Protected Health Information that may be requested from time to time by the person(s) I identify in Section D. below.**
2. _______	**All my Protected Health Information related to one or more of the following:**
	Description of Claim:
	Time frame(s) of Service:
	Name of Provider:
3. _______	**All my protected health information related to:**
	Date of Accident/Incident:
	Type of Accident/Incident:
	Member's Injury:
4. _______	**Other. Here is a specific description of my Protected Health Information to be disclosed:**

C. Person(s) Authorized To Disclose My Protected Health Information.

By signing this authorization, I hereby authorize Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of my Health Plan (identified by the Contract Number above) to disclose my Protected Health Information. **I understand that information contained in my protected health information may include information related to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.**

D. Person(s) Authorized To Receive My Protected Health Information.

Name(s):	
Address(es):	
Telephone(s):	

By signing this authorization, I understand that my Protected Health Information described herein may be redisclosed by the person(s) I have authorized to receive and use my Protected Health Information and that my Protected Health Information described herein may no longer be protected by federal privacy laws.

E. Purpose of This Disclosure of My Protected Health Information.

☐ **At my request**	☐ **Litigation** (Style of Case & Number): _______________	☐ **Other** (Please Specify): _______________

(Continue on back)

F. Date of Expiration of this Authorization.

☐	Until my coverage under my Health Plan (identified by the Contract Number above) terminates.
☐	Expiration Date or Event:

If no expiration date is indicated, this authorization will expire in one year from the date of this authorization.

G. Right to Revoke this Authorization.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed below. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you received my written notice of revocation.

Blue Cross and Blue Shield of Alabama
Attention: Privacy Office
Post Office Box 2643
Birmingham, Alabama 35202-2643

H. Signature:

I, ____ , have had full opportunity to read and consider the contents of this authorization. I understand that my Health Plan will not condition its payment activities in connection with my claims, or my enrollment in my Health Plan, or my eligibility for benefits or treatments upon my giving this authorization.

Signature:	**Date:**
***Personal Representative Signature:**	**Date:**

* If signed as a Personal Representative, you must describe your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization ("Individual") **by initialing one of the following:**

________	The Individual is an unemancipated minor child, I am the parent and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Please Note: You should consult your state's laws to find out if you have legal authority to make health care decisions for your child. If you are unsure whether you have such legal authority, both you and your child must sign this treatment. For example: In the State of Alabama a child 14 years old or older has the authority to make healthcare decisions and must sign this authorization.***
________	The Individual is an adult, unemancipated minor or emancipated minor, I am the guardian, attorney-in-fact or other authorized representative and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters of guardianship.***
________	The Individual is deceased, I am the executor, administrator or other person authorized under applicable law to act on behalf of the Individual's estate, and the health information described herein is relevant to my personal representation of the Individual or the Individual's estate. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters testamentary or letters of administration.***

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT.