MUS_EB
Montana University System
Employee Benefits

ATTENDING PHYSICIAN'S STATEMENT FOR IMPAIRED/DISABLED DEPENDENT CHILD

PART A TO BE COMPLETED BY EMPLOYEE

Name of Employer: (PLEASE PRINT)	
Name of Employee:	
Name of Covered Dependent Child (over age 26):	Date of Birth:
Please indicate the nature of the child's mental or physical impairment or disability:	

Do you have physical custody of this child? *	_____ YES _____ NO
Do you have legal custody of this child? *	_____ YES _____ NO
Does this child reside with you on a full-time basis? *	_____ YES _____ NO
Is this child fully dependent on you for support and maintenance? *	_____ YES _____ NO

*If you answer "NO" to these questions, but you are required to provide coverage due to a court order or divorce decree for an impaired or disabled dependent child not in your custody or not wholly dependent upon you for support, please indicate and provide a copy of the order requiring you to provide medical coverage for this dependent.

Does this child have any other medical coverage?	_____ YES _____ NO

If the child does have other medical coverage, please indicate below:

__	Group or Individual Coverage (indicate plan name and plan identification number) _____
__	TRICARE/CHAMPVA (Coverage through the United States Armed Forces)
__	Worker's Compensation (name of carrier) _____
__	Medicaid
__	Medicare
__	Other (please describe) _____

Please indicate the child's level of education, if applicable:

__ Not applicable __ Elementary __ Junior High __ High School __ College
__ Vocational/Occupational Training __ Special Education __ Other (please describe) _____

Is the child presently attending school? ___ YES ___ NO

__ High School __ College __ Vocational/Occupational Training __ Special Education

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, pharmacy or any other health care provider, any insurance company or any government agency to disclose all information and records relating to diagnosis, treatment, medical history and evaluation, physical and mental condition or any other relevant information concerning the above-named dependent child to Allegiance Benefit Plan Management, the Medical Plan Claims Administrator of my group health plan. I understand that such information will be used, now or in the future, only for purpose of determining if the above-named dependent child is or remains eligible for dependent coverage and benefits under the terms and conditions of my group health plan. I understand that any information provided will be kept confidential and will not be released to any person or organization other than the group health plan's stop-loss insurance carrier, the Medical Plan Claims Administrator's employees who require such information to complete work assigned to them, to any authorized and properly identified governmental regulatory authority, as otherwise required by law or as I may further authorize. A photocopy of this authorization shall be as valid as the original. This authorization shall remain in force for as long as I remain covered under the group health plan unless I affirmatively revoke this authorization in writing. I understand that I have a right to receive a copy of this authorization upon request.

Signature of Employee: _____ **Date:** _____

PART B TO BE COMPLETED BY HEALTH CARE PROVIDER

NOTICE TO PROVIDER: The Plan cannot determine eligibility or process claims without sufficient information to determine if the dependent child shown in PART A is eligible under the terms and conditions of the Plan. State law provides that a health care provider may disclose health care information about a patient to a third-party health care payor who requires health care information provided that the third-party payor cannot use or disclose the health care information for any other purpose and takes appropriate steps to protect the health care information. [50-16-529 (2) MCA] Please be assured that the confidentiality of the information you provide will be maintained. We have, and strictly enforce, policies concerning confidential medical information. Confidential information is provided to employees on a "must know" basis as needed to complete the work assigned to them. Allegiance Benefit Plan Management does not disclose confidential medical information without the express written permission of the party controlling the information or to a legally authorized and properly identified governmental regulatory authority unless such disclosure is (a) necessary and appropriate to complete the work assigned, (b) specifically authorized in writing by the controlling party, or (c) compelled by applicable law. Please attach any supporting documentation which you believe will assist in determining eligibility.

NATURE OF IMPAIRMENT/DISABILITY AND DIAGNOSIS:

HISTORY:

Is the impairment due to: ___ Accident ___ Illness ___ Complication of Birth/Congenital
___ Other (please describe) _____

DATE OF ONSET/ACCIDENT: Month _____ Day _____ Year _____

DETAILS OF IMPAIRMENT/DISABILITY:

Is the impairment/disability: ___ Mental ___ Physical ___ Developmental
___ Other (please describe) _____
Is the patient: ___ Ambulatory ___ Bed Confined ___ House Confined ___ Hospital Confined

Please indicated the functions/skills the patient has difficulty with:

Mental: ___ Cognitive ___ Limited Capacity ___ Comatose/Unconscious
Speech: ___ Unable to speak ___ Speaks with difficulty ___ Speaks without difficulty
Ambulation: ___ Unable to walk ___ Walks with difficulty ___ Walks without difficulty
Mobility/Dexterity: ___ Unable to use arm(s) ___ Unable to use hand(s)
Learning (please describe): _____
Daily Life Activities: ___ Bathing ___ Dressing ___ Feeding ___ Full Custodial Care Needed
Has patient been hospital confined? ___ Yes ___ No
If yes, give name and address of hospital and date(s) of confinement: _____
Is patient capable of attending school or receiving vocational/occupational training? ___ YES ___ YES, but has special needs ___ NO

DATES OF TREATMENT (include name(s) and date(s) of any surgery, medications prescribed, therapy, etc.):

Date of first visit Month _____ Day _____ Year _____
Date of most recent visit Month _____ Day _____ Year _____
How frequently do you see this patient? _____

EMPLOYMENT:

Is this individual capable of self-supporting employment? ___ YES ___ NO
If not, please indicate reason(s): _____
Will this individual be capable of self-supporting employment in the future? ___ YES ___ NO
If no, please indicate reason(s) _____

PROGRESS AND PROGNOSIS:

Has patient: ___ Recovered ___ Improved ___ Stayed the same ___ Retrogressed
Is the patient's condition expected to: ___ Recover ___ Improve ___ Stay the same ___ Decline

I affirm that the above information is correct. I authorize any hospital in which confinement took place to furnish Allegiance Benefit Plan Management full information and disclose all facts concerning the condition of the Dependent Child (patient) shown on the reverse of this form. A photocopy shall be as valid as the original.

Name of Attending Physician (please print) _____ **Degree** _____

Street Address _____ **City**_____ **State** _____ **Zip Code** _____
Telephone # _____

Signature of Attending Physician _____ **Date** _____