



**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 BlueCross BlueShield of Montana, 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. BlueCross BlueShield of Montana 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 BlueCross BlueShield of Montana 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** _____