



# Disabled Dependent Review Process – Certification Form

(For Individual and Family Plans)

## PLEASE READ CAREFULLY

To determine if your dependent qualifies for disabled dependent benefits past age 26, completion of this form by the policyholder and attending physician is required.

## DIRECTIONS

1. The policyholder must complete and sign the **Disabled Dependent Authorization** section.
2. A licensed physician or mental health professional must complete and sign the **Disabled Dependent Physician Certification** section. Please complete the form in its entirety, as applicable. If more space is needed, use an additional sheet of paper or attach copies of medical records/progress notes.
3. Mail the completed form to:

Blue Cross and Blue Shield of Oklahoma  
P.O. Box 3238  
Naperville, IL 60566-7238  
Or fax to: 800-279-7419

Upon completion of the review process, the policyholder and/or their employer group will receive a letter advising of the determination and coverage dates if applicable. Please allow up to 30 business days for review completion.

If you have questions, please contact customer service using the phone number on your medical insurance ID card.



P.O. Box 3238, Naperville, IL 60566-7238
Fax: 800-279-7419

TO BE FILLED OUT BY THE POLICYHOLDER

Form with 9 numbered sections for policyholder and dependent information, including name, address, birthdate, sex, age, and disability status.

When I provide an original or copy of this signed form, I am allowing any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide Blue Cross and Blue Shield of Oklahoma (BCBSOK) with information.

I understand that such information will be used by BCBSOK for the purpose of certifying the above named dependent as disabled for purpose of coverage under my health insurance. I understand that I or any other authorized representative will receive a copy of this authorization upon request.

I certify that the above information is correct to the best of my knowledge and belief.

Signature and Date Signed fields



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**TO BE FILLED OUT BY THE ATTENDING PHYSICIAN**



**NOTE:** Any fee for the completion of this form is the responsibility of the policyholder.

PATIENT NAME		
PHYSICIAN NAME	PHYSICIAN PHONE NUMBER	
PHYSICIAN ADDRESS		
DATE OF FIRST VISIT (MM/DD/YYYY) / /	FREQUENCY OF VISITS	LAST EXAM DATE (MM/DD/YYYY) / /



**NOTE:** Please complete the form in its entirety, as applicable. If more space is needed, use an additional sheet of paper or attach copies of medical records/progress notes.

**PRIMARY DIAGNOSIS (REQUIRED)**

PHYSICAL: ICD-10 CODES	BEHAVIORAL: ICD-10 CODES	DATE OF ONSET OF INCAPACITATING DIAGNOSIS (MM/DD/YYYY) / /
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**NATURE OF THE DISABILITY (REQUIRED)**

PLEASE DESCRIBE: ETIOLOGY/CAUSE, SEVERITY, CURRENT SIGNS AND SYMPTOMS

**DAILY LIVING (REQUIRED)**

PLEASE GIVE DETAILS REGARDING: TYPICAL DAY'S ACTIVITY AND DEGREE OF ASSISTANCE NEEDED TO COMPLETE THESE ACTIVITIES

PROVIDE SPECIFIC LIMITATIONS AND THE IMPACT THEY HAVE ON GAINFUL EMPLOYMENT

WHEN DO YOU THINK THE PATIENT WILL BE ABLE TO RETURN TO GAINFUL EMPLOYMENT?

APPROXIMATE DATE: / /  INDEFINITE  NEVER

**FOR MENTAL DISABILITY (IF APPLICABLE)**

PHYSICAL & COGNITIVE LIMITATIONS	IQ TESTING RESULTS
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**TREATMENT PLAN (REQUIRED)**

INCLUDE PREVIOUS, CURRENT, AND PLANNED TREATMENT; TREATMENT GOALS AND PROJECTED DURATION OF TREATMENT

**SECONDARY SUPPORTING DIAGNOSIS (IF APPLICABLE)**

CURRENT SIGNS AND SYMPTOMS SECONDARY TO THE DIAGNOSIS

NAME OF PHYSICIAN (PRINT OR TYPE)	CREDENTIALS
PHYSICIAN'S SIGNATURE	DATE SIGNED