BlueCross BlueShield of New Mexico

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 New Mexico
   P.O. Box 660819
   Dallas, TX 75266-0819

   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.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, Claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, disability, blindness, partial blindness or any other health status related factor. You will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

UN65-Disabled Dependent Certification-2023

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BlueCross BlueShield of New Mexico

Disabled Dependent Authorization

P.O. Box 660819, Dallas, TX 75266-0819
Fax: 800-279-7419

TO BE FILLED OUT BY THE POLICYHOLDER

1. NAME OF POLICYHOLDER (PRINT – LAST, FIRST & MIDDLE INITIAL)	1A. BLUE CROSS AND BLUE SHIELD OF NEW MEXICO NUMBERS GROUP NUMBER MEMBER ID NUMBER	
2. POLICYHOLDER'S ADDRESS (NUMBER, STREET, CITY, STATE & ZIP CODE)		
3. DEPENDENT'S NAME		3A. DEPENDENT'S BIRTHDATE (MM/DD/YYYY) / /
3C. DEPENDENT'S RELATIONSHIP TO POLICYHOLDER	3D. DEPENDENT'S SEX ☐ MALE ☐ FEMALE	3E. DEPENDENT'S AGE WHEN DISABILITY OCCURRED

4. IS DEPENDENT PERMANENTLY RESIDING IN YOUR HOUSEHOLD? IF **NO**, PLEASE EXPLAIN. IF MORE SPACE IS NEEDED USE AN ADDITIONAL SHEET OF PAPER.	☐ YES ☐ NO
5. IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT? IF **YES**, WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE? %	☐ YES ☐ NO
5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?	☐ YES ☐ NO
6. WAS DEPENDENT EVER EMPLOYED?	☐ YES ☐ NO
6A. IS DEPENDENT NOW EMPLOYED?	☐ YES ☐ NO
7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO REACHING AGE 26?	☐ YES ☐ NO
8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?	☐ YES ☐ NO
9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE? IF **YES**, PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER. INSURANCE COMPANY GROUP, CERTIFICATE OR AGREEMENT NUMBER	☐ YES ☐ NO

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 New Mexico (BCBSNM) with information. This may include copies of records concerning advice, care or treatment provided to the dependent named above, including, without limitation, information relating to mental illness, use of drugs or alcohol.

I understand that such information will be used by BCBSNM 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. This authorization to collect medical information is valid from the date signed for a period of two and one-half years.

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

SIGNATURE OF POLICYHOLDER	DATE SIGNED

BlueCross BlueShield of New Mexico

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Disabled Dependent Physician Certification

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) / /

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

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