

DISABLED DEPENDENT EVALUATION FORM



SECTION I: TO BE COMPLETED BY THE SUBSCRIBER

1. Subscriber Name _____ ID Number _____
2. Home Address _____
3. Dependent's Name _____ Birth Date ____ / ____ / ____
4. Dependent's Relationship to Subscriber _____
5. Dependent's Address _____
6. Name(s) of Condition _____
7. First Treatment of the Condition (month/year) _____ / _____
8. Most Recent Treatment of the Condition (month/year) _____ / _____
9. Attend School YES Part-time (hours per week) _____ Full-time _____
 NO If no, why not _____
10. Able to work YES Presently working at _____ Hours per week _____
 NO If no, why not _____
How does the condition prevent him/her from working? _____
When last worked _____ Where last worked _____
Description of work _____
11. Has the dependent applied for supplemental security income (SSI) or social security disability (SSDI)? YES NO
12. Has the dependent been found eligible as disabled by supplemental security income (SSI) or social security disability insurance (SSDI)? (If yes, documentation is required to evaluate disabled dependent coverage. Example: Notice of award letter) YES NO
13. Has the dependent been found eligible by the State of Massachusetts for any services due to his/her condition?
 YES NO
If yes, include any individualized service plan created in connection with such services. _____
14. The dependent listed above is the natural child, stepchild or adoptive child of my spouse or myself and is over the age of 26. YES NO
15. The dependent listed above resides with my spouse or me. YES NO
If no, please explain _____
16. The dependent had health insurance coverage immediately prior to the request of the new effective date.
 YES NO
Please attach a certificate of creditable coverage or termination letter of prior coverage.
Date Previous Insurance Ended ____ / ____ / ____

All questions must be answered completely for application to be processed.

I authorize medical release of information to Tufts Health Plan medical directors for review and I attest to the accuracy of the information contained within this form.

Signature of Subscriber _____ Date ____ / ____ / ____

SECTION II: TO BE COMPLETED BY THE PROVIDER PRIMARILY RESPONSIBLE FOR TREATING THE CONDITION

1. Patient Name _____
2. Name of the provider who treats the patient for their condition _____
Specialty of provider treating the condition _____
3. Date of first visit with the patient _____ / _____ / _____
4. Date of most recent visit with the patient _____ / _____ / _____
5. Diagnosis _____ DSM-IV Diagnosis, if applicable _____
IQ _____ Mental Age _____
6. To your knowledge, length of time this condition has existed _____
7. Indicate date that the condition resulted in marked and severe functional limitations such that the dependent became unable to attend school, live, or function independently on a daily basis _____ / _____ / _____
Please describe _____
8. From the time of the first visit, the condition has Improved Remained Stable Deteriorated Not remained in evidence
Description of physical and/or mental condition and the functional impairments _____

9. In your professional opinion, is this dependent described above, physically and/or mentally capable of returning to school or work? (this information is required to evaluate dependents coverage)
 YES Please indicate how many hours per week _____
 NO If no, please attach any relevant medical documentation, including office notes, progress reports, and treatment plans that supports disability status and incapability of financial self support or describe below:

10. In your professional opinion, does the condition appear to be:
 Permanent Temporary, Length of time _____ No Longer In Evidence
11. In your professional opinion, does the disability (inability to attend school or work) appear to be:
 Permanent Temporary, Length of time _____ No Longer In Evidence

ATTESTATION

Section II of this document has been completed by (print) _____,
the dependent's doctor or treating provider and is accurate to the best of his/her ability.

Office Address _____ City _____ State _____ Zip _____
Office Telephone Number _____ Office Fax Number _____
Physician Signature _____ Date _____ / _____ / _____
Physician's Specialty _____

Mail both sections of this form to:

Tufts Health Plan, Commercial Enrollment P.O. Box 9186 Watertown, MA 02471-9186