DISABLED DEPENDENT EVALUATION FORM

TUFTS Health Plan

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 Rhode Island 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 expl ain_____

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