

# 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 for services by the Department of Developmental Services?  YES  NO  
If yes, include the ISP (Individualized Service Plan) \_\_\_\_\_
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 other 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