

Tufts Health Plan Disabled Dependent Evaluation Form

SECTION I: TO BE COMPLETED BY SUBSCRIBER

1. SUBSCRIBER NAME: _____ ID NUMBER: _____
2. HOME ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
3. DEPENDENT'S NAME: _____ BIRTH DATE: ___/___/___
4. DEPENDENT'S RELATIONSHIP TO SUBSCRIBER: _____
5. DEPENDENT'S ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
6. NAME OF PROVIDER TREATING CONDITION: _____
❖ MEDICAL SPECIALTY: _____
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): _____ OR FULL-TIME:
NAME OF SCHOOL: _____ SEMESTER DATE: _____
 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. YES NO LAST YEAR DID YOU OR YOUR SPOUSE CLAIM THIS DEPENDENT AS AN EXEMPTION ON YOUR FEDERAL TAX FORMS FILED WITH THE INTERNAL REVENUE SERVICE (IRS)? **IF NO, PLEASE INDICATE THE LAST YEAR YOU CLAIMED THIS DEPENDENT.** _____
12. YES NO HAS THE DEPENDENT APPLIED FOR SUPPLEMENTAL SECURITY INCOME (SSI) OR SOCIAL SECURITY DISABILITY?
13. YES NO 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)**
14. YES NO THE DEPENDENT LISTED ABOVE IS THE NATURAL CHILD, STEPCHILD OR ADOPTIVE CHILD OF MY SPOUSE OR MYSELF AND IS OVER THE AGE OF 21.
15. YES NO THE DEPENDENT LISTED ABOVE RESIDES WITH MY SPOUSE OR ME.
IF NO, PLEASE EXPLAIN: _____
16. YES NO HAD OTHER HEALTH INSURANCE COVERAGE **IMMEDIATELY** PRIOR TO THE REQUEST OF THE NEW EFFECTIVE DATE. PLEASE ATTACH A CERTIFICATE OF CREDITABLE COVERAGE OR SUPPLY THE FOLLOWING INFORMATION:
NAME OF INSURANCE CARRIER: _____
POLICY NUMBER: _____
TELEPHONE NUMBER: _____
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: _____
- 6. TO YOUR KNOWLEDGE, LENGTH OF TIME THIS CONDITION HAS EXISTED: _____
- 7. INDICATE DATE THAT THE CONDITION RESULT 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 THAT RESULT:

- 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

- 12. DSMIV DIAGNOSIS, IF APPLICABLE: _____

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**