**Return to:** Dependent Certification Department
P.O. Box 77
Pittsburgh, PA 15230

HIGHMARK

# DISABLED DEPENDENT CERTIFICATION

## TO BE COMPLETED BY EMPLOYEE/PENSIONER

| 1. Name of Employee/Pensioner/Surviving Spouse (print - last, first & middle initial) | 2. Group Number | 3. Identification Number |
|---|---|---|
| | | |

4. Employee/Pensioner/Surviving Spouse Address (number, street, city, state, & zip code)

5. Disabled Dependent's Name

Disabled Dependent's Birthdate
Month Day Year

Disabled Dependent's Marital Status
❑ Single ❑ Married
❑ Widowed ❑ Divorced

Disabled Dependent's Relationship to Employee/Pensioner

Disabled Dependent's Sex
❑ Male ❑ Female

Disabled Dependent's Age When Disability Occurred

6. Is dependent permanently residing in your household? ❑ Yes ❑ No If "No", please explain: _____

7. Do you provide 50% or more financial support to the dependent? ❑ Yes ❑ No If "No", please explain: _____

8. Is dependent listed as a dependent in your last Federal Income Tax Return? ❑ Yes ❑ No If "No", please explain: _____

9. Was the dependent certified as a student dependent at the time of the disability? ❑ Yes ❑ No

10. Current student status: ❑ Full time ❑ Part time ❑ Not Applicable

11. Was dependent ever employed? ❑ Yes ❑ No

12. Is dependent employed now? ❑ Yes ❑ No

13. If answer to question 11 or 12 is "Yes", give name(s) and address(es) of employer(s) and date(s) employed: _____

14. Was dependent covered under your (former) employer's program prior to age of deletion? ❑ Yes ❑ No

15. Disabled dependent's Social Security Number _____

16. Is dependent now covered under Medicare or any other hospital-medical coverage? ❑ Yes ❑ No If "Yes", please complete the following:

Medicare Health Insurance Claim Number _____

Hospital Insurance (PART A) Effective Date _____

Medical Insurance (PART B) Effective Date _____

*If covered by other insurance, please print name of the employer, the insurance company name, and your certificate or agreement number on the reverse side hereof.*

17. OTHER HOSPITAL/MEDICAL INSURANCE

Policyholder name _____ Employer name & phone number _____

Insurance Carrier name & phone number _____

Policy and/or Social Security Number _____ Effective date of coverage _____

**NOTE:** If you have not already done so, it may be to your financial advantage to contact Social Security and apply for Social Security Disability payments and/or Medicare Health Insurance or Supplemental Security Income (SSI) and/or Medicaid on behalf of your disabled dependent.

**I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information requested with respect to this certification.** ( ) _____ ( ) _____

_____ _____

**Signature of Employee/Pensioner or Surviving Spouse** **Date Signed** **Home Phone #** **Work Phone #**

## TO BE COMPLETED BY ATTENDING PHYSICIAN

**DIRECTIONS TO ATTENDING PHYSICIAN:**

- **Please complete all areas of this form and then proceed to the Level of Impairment chart and circle one appropriate indicator per category.**
- **Your prompt completion of this form will expedite the disability application process.**
- **Any fee for completion of this form and other forms for dependent disability determination is the responsibility of the employee.**

Is dependent now incapable of self-support because of disability? ❑ Yes ❑ No

Has such disability existed continuously since before dependent attained age 19? ❑ Yes ❑ No

When did present illness begin or injury occur? Date: _____

Does the patient have a previous history of this illness? ❑ Yes ❑ No

If "Yes", please explain: _____

Date disability commenced: _____

Subjective symptoms: _____

Objective findings (please provide dates of surgery, x-rays, or other tests): _____

Diagnosis description or medical history and medications (please give as much detail as possible): _____

Date of last office visit: _____ Frequency of visits: _____

PROGRESS: ❑ Recovered ❑ Improved ❑ Unimproved ❑ Regressed

Prognosis for employment: _____

| NAME OF PHYSICIAN (please print) | TELEPHONE NUMBER | DEGREE |
|---|---|---|
| | | |

ADDRESS OF PHYSICIAN

| PHYSICIAN'S SIGNATURE | DATE |
|---|---|
| | |

ADDITIONAL COMMENTS: _____

# LEVEL OF IMPAIRMENT SCALE

**NOTE: Any fee for the completion of this and other forms for dependent disability is the responsibility of the employee.**

| | |
|---|---|
| * | **requires minimal help < 25% of the time.** |
| * * | **requires moderate help 25 - 50% of the time.** |
| * * * | **requires major help 50 - 75% of the time.** |

Dependent meets eligibility requirements of the groups as verified by completion of the Disabled Dependent Certification form. ❑ YES ❑ NO

If NO, refer: _____

**GUIDELINES**

A. Medical Diagnosis: _____

B. Level of Impairment: _____

| **CIRCLE A RATING FOR EACH CATEGORY** | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| motor | self sufficient | needs minimal help * | needs moderate help ** | needs major help *** | dependent |
| functional (ADLs) | self sufficient | needs minimal help * | needs regular help ** | needs major help *** | dependent |
| mental capacity | no deficit | slight deficit | moderate deficit | mod/severe deficit | severe deficit |
| judgement | no deficit | slight deficit | moderate deficit | mod/severe deficit | severe deficit |
| rehab potential | excellent | good | good for partial restoration | condition static | condition will worsen |
| employment | excellent | good | good for part-time employment | good for low level employment | poor |
| **Total** | _____ | _____ | _____ | _____ | _____ |

**Sum 1+2+3+4+5** _____

C. Mental Nervous Diagnosis: _____

D. Level of Impairment: _____

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| intelligence | normal or better | mildly intellectually disabled | moderately intellectually disabled | severely intellectually disabled | profoundly intellectually disabled |
| perception | no deficit | slight deficit | moderate deficit | mod/severe deficit | severe deficit |
| thinking | no deficit | slight deficit | moderate deficit | mod/severe deficit | severe deficit |
| judgement | no deficit | slight deficit | moderate deficit | mod/severe deficit | severe deficit |
| affect | normal | slight problem | moderate problem | mod/severe problem | severe problem |
| behavior | normal | slight problem | moderate problem | mod/severe problem | severe problem |
| functional (ADLs) | self sufficient | needs minimal help | needs regular help | needs major help | dependent |
| intelligence potential | excellent | good | good for partial | condition static | condition will worsen |
| **Total** | _____ | _____ | _____ | _____ | _____ |

**Sum 1+2+3+4+5** _____

Patient Name: _____ Agreement Number: _____

Physician Name: _____ Signature: _____

**Discrimination is Against the Law**

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.