



BlueCross BlueShield
of Illinois

Disabled Dependent Review Process – Certification Form (Boeing)

PLEASE READ CAREFULLY

To determine if your dependent qualifies for disabled dependent benefits past age 26, completion of this form by the member/subscriber and attending physician is required.

DIRECTIONS

1. The member/subscriber must complete and sign the **Disabled Dependent Authorization** section.
2. A licensed physician or mental health professional must complete and sign the **Disabled Dependent Physician Certification** section. Please complete the form in its entirety, as applicable. If more space is needed, use an additional sheet of paper or attach copies of medical records/progress notes.
3. Mail the completed form to:

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603

Or fax to: 217-243-2151

Upon completion of the review process, the member/subscriber and/or their employer group will receive a letter advising of the determination and coverage dates, if applicable. Please allow up to 30 business days for review completion.

If you have questions, please contact customer service using the phone number on your medical insurance ID card.



Disabled Dependent Authorization

1. NAME OF MEMBER/SUBSCRIBER (PRINT – LAST, FIRST & MIDDLE INITIAL)		1A. BLUE CROSS AND BLUE SHIELD OF ILLINOIS NUMBERS GROUP NUMBER		MEMBER ID NUMBER
2. MEMBER'S/SUBSCRIBER'S ADDRESS (NUMBER, STREET, CITY, STATE & ZIP CODE)				
3. DEPENDENT'S NAME			3A. DEPENDENT'S BIRTHDATE (MM/DD/YYYY) / /	
3C. DEPENDENT'S RELATIONSHIP TO MEMBER/SUBSCRIBER		3D. DEPENDENT'S SEX ☐ MALE ☐ FEMALE		3E. DEPENDENT'S AGE WHEN DISABILITY OCCURRED
4. IS DEPENDENT PERMANENTLY RESIDING IN YOUR HOUSEHOLD? IF NO , PLEASE EXPLAIN. IF MORE SPACE IS NEEDED USE AN ADDITIONAL SHEET OF PAPER.				☐ YES ☐ NO
5. IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT? IF YES , WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE? _____ %				☐ YES ☐ NO
5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?				☐ YES ☐ NO
6. WAS DEPENDENT EVER EMPLOYED?				☐ YES ☐ NO
6A. IS DEPENDENT NOW EMPLOYED?				☐ YES ☐ NO
7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO REACHING AGE 26?				☐ YES ☐ NO
8. IS DEPENDENT CONSIDERED DISABLED UNDER SOCIAL SECURITY DISABILITY INSURANCE (SSDI)?				☐ YES ☐ NO
9. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE? IF YES , PROVIDE NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER. INSURANCE COMPANY: GROUP, CERTIFICATE OR AGREEMENT NUMBER:				☐ YES ☐ NO

I certify that the above information is correct to the best of my knowledge and belief.

SIGNATURE OF MEMBER/SUBSCRIBER	DATE SIGNED
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TO BE FILLED OUT BY THE ATTENDING PHYSICIAN

NOTE: Any fee for the completion of this form is the responsibility of the member/subscriber.

PATIENT NAME		
PHYSICIAN NAME		PHYSICIAN PHONE NUMBER
PHYSICIAN ADDRESS		
DATE OF FIRST VISIT (MM/DD/YYYY) / /	FREQUENCY OF VISITS	LAST EXAM DATE (MM/DD/YYYY) / /


NOTE: Please complete the form in its entirety, as applicable. If more space is needed, use an additional sheet of paper or attach copies of medical records/progress notes.

PRIMARY DIAGNOSIS (REQUIRED)		
PHYSICAL: ICD-10 CODES	BEHAVIORAL: ICD-10 CODES	DATE OF ONSET OF INCAPACITATING DIAGNOSIS (MM/DD/YYYY) / /
NATURE OF THE DISABILITY (REQUIRED)		
PLEASE DESCRIBE: ETIOLOGY/CAUSE, SEVERITY, CURRENT SIGNS AND SYMPTOMS		
DAILY LIVING (REQUIRED)		
PLEASE GIVE DETAILS REGARDING: TYPICAL DAY'S ACTIVITY AND DEGREE OF ASSISTANCE NEEDED TO COMPLETE THESE ACTIVITIES		
PROVIDE SPECIFIC LIMITATIONS AND THE IMPACT THEY HAVE ON GAINFUL EMPLOYMENT		
WHEN DO YOU THINK THE PATIENT WILL BE ABLE TO RETURN TO GAINFUL EMPLOYMENT?		
APPROXIMATE DATE: / / ☐ INDEFINITE ☐ NEVER		
FOR MENTAL DISABILITY (IF APPLICABLE)		
PHYSICAL & COGNITIVE LIMITATIONS		IQ TESTING RESULTS
TREATMENT PLAN (REQUIRED)		
INCLUDE PREVIOUS, CURRENT, AND PLANNED TREATMENT; TREATMENT GOALS AND PROJECTED DURATION OF TREATMENT		
SECONDARY SUPPORTING DIAGNOSIS (IF APPLICABLE)		
CURRENT SIGNS AND SYMPTOMS SECONDARY TO THE DIAGNOSIS		

NAME OF PHYSICIAN (PRINT OR TYPE)	CREDENTIALS
PHYSICIAN'S SIGNATURE	DATE SIGNED