BlueCross BlueShield of North Carolina

North Carolina State Health Plan

North Carolina HEALTH Smart

RETURN COMPLETED FORM TO:
North Carolina State Health Plan
PO Box 30111 • Durham, NC 27702-3111

☐ **Coverage Request for a Mentally or Physically Incapacitated Child**

☐ **Recertification Request**

SECTION A – TO BE COMPLETED BY MEMBER

1	NAME OF MEMBER	ADDRESS OF MEMBER		MEMBER ID NUMBER
2	NAME OF DEPENDENT	SOCIAL SECURITY NUMBER OF DEPENDENT	DEPENDENT'S DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED
3	WAS DEPENDENT EVER INSTITUTIONALIZED? ☐ YES → **IF YES,** GIVE NAME AND ADDRESS OF INSTITUTION(S).....AND → ☐ NO			PERIOD CONFINED FROM: TO:
4	IS DEPENDENT ELIGIBLE FOR CARE UNDER FEDERAL, STATE OR LOCAL LAW? ☐ YES → **IF YES,** GIVE DETAILS: ☐ NO			
5	IS DEPENDENT ELIGIBLE FOR MEDICARE? ☐ YES → **IF YES,** GIVE EFFECTIVE DATES: ☐ NO PART A PART B			
6	WAS, OR IS, DEPENDENT EMPLOYED FOR WAGES? ☐ YES → **IF YES,** GIVE NAME AND ADDRESS OF CURRENT OR LAST EMPLOYER: ☐ NO			AVERAGE WEEKLY EARNINGS: $
7	IF DEPENDENT WAS EMPLOYED, GIVE REASON FOR TERMINATION:			
8	IS DEPENDENT CHILD CURRENTLY COVERED UNDER YOUR PRESENT COVERAGE? ☐ YES ☐ NO	IS DEPENDENT CHILD CURRENTLY COVERED UNDER A SEPARATE CONTRACT? ☐ YES → **IF YES,** GIVE MEMBER ID NUMBER ☐ NO		
9	IS DEPENDENT CHILD CURRENTLY CLAIMED FOR INCOME TAX EXEMPTION UNDER THE U.S. INTERNAL REVENUE CODE? ☐ YES ☐ NO	**SIGNATURE OF MEMBER:**		DATE SIGNED:
10	WAS THE DATE OF INCAPACITATION PRIOR TO AGE 19? ☐ YES ☐ NO			
11	WAS THE DATE OF INCAPACITATION BETWEEN 19 AND 26? ☐ YES ☐ NO	**AND**	WAS CHILD COVERED BY THE PLAN AS A FULL-TIME STUDENT? ☐ YES ☐ NO	

SECTION B – TO BE COMPLETED BY CERTIFYING PHYSICIAN

IS DEPENDENT PRESENTLY INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF: ☐ MENTAL INCAPACITATION ☐ PHYSICAL HANDICAP	IS INCAPACITY CONGENITAL? ☐ YES ☐ NO	DATE OF INCAPACITATION **OR** DATE OF ONSET OF INCAPACITATION:
DIAGNOSIS OF CONDITIONS CAUSING INCAPACITATED STATUS:		
WILL THIS DEPENDENT BE INCAPABLE OF SELF-SUSTAINING EMPLOYMENT FOR AN EXTENDED PERIOD OF ONE YEAR OR LONGER? ☐ YES → **IF YES,** HOW LONG?.....AND → ☐ NO		IS DEPENDENT PERMANENTLY INCAPACITATED? ☐ YES ☐ NO
PLEASE PROVIDE DETAILS EXPLAINING THE DEGREE OF INCAPACITATION AND/OR FUNCTIONAL LEVEL, TREATMENT AND PROGNOSIS:		
IF ADMITTED AS INPATIENT, GIVE NAME OF HOSPITAL:		DATE ADMITTED:
NAME OF CERTIFYING PHYSICIAN:	ADDRESS:	
SIGNATURE OF CERTIFYING PHYSICIAN:		DATE SIGNED:

SECTION C – FOR INTERNAL OFFICE USE ONLY

	BY	DATE	REMARKS:
REC'D			
APP'D			
EFFEC			

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WHITE – SUBMIT TO CLAIMS PROCESSING CONTRACTOR YELLOW – EMPLOYEE