Blue Cross Blue Shield Blue Care Network of Michigan

Incapacitated Dependent Application for State Health Plan PPO and State High Deductible Health Plan (Blue Cross) and Blue Care Network members

Note: This application is ONLY for members who are employees or retirees of the State of Michigan

Guidelines and instructions

Complete the application on page 2 if you are a State of Michigan employee or retiree with a Blue Cross or BCN health plan that would like to continue coverage for an incapacitated dependent.

Incapacitated dependent (definition for employees and retirees based on the State of Michigan's plan requirements)

Incapacitated dependents of State of Michigan employees and retirees are defined as those unable to earn a living because of developmental disability or physical disability and must rely on their parents for support and maintenance. For more information on incapacitated dependent guidelines, please visit **www.michigan.gov/employeebenefits**.

For questions about incapacitated eligibility, please call the Employee Benefits Division at **1-800-505-5011**, Monday through Friday from 8 a.m. to 5 p.m. Eastern time.

Application instructions

If your dependent meets these guidelines, please complete and sign page 2 of this application. Your dependent's physician must complete and sign page 3 of this application.

Note: If you're applying for more than one dependent (e.g., twins), you must complete and mail a separate application for each dependent.

Submit the completed application by email or fax:

Email: **ksasom@bcbsm.com**
Subject: ATTN: Senior Medical Analyst

Fax: **1-866-392-7577**
ATTN: Senior Medical Analyst

Once we receive your application, we'll review and determine if your dependent can continue under your state-sponsored benefits as an incapacitated dependent. If your dependent does not meet the State of Michigan's Dependent Eligibility Guidelines, they will be considered ineligible and will be removed from your coverage.

Questions regarding this application?

State Health Plan PPO and State High Deductible Health Plan (Blue Cross) members call **1-800-843-4876**. We're open Monday through Friday from 7 a.m. to 7 p.m. Eastern time. TTY users call **711**.

Blue Care Network (BCN) members call **1-800-662-6667**. We're open Monday through Friday from 8 a.m. to 5:30 p.m. Eastern time. TTY users call **711**.

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(For State of Michigan employees and retirees ONLY)

Please complete online, print form and mail to the address on the prior page.
Keep a copy of the completed form for your records.

Section A: Subscriber information

Name		Contract number		
Birth date	Martial status ☐ Single ☐ Married	Sex ☐ Male ☐ Female		
Primary residence: Street address	City	County	State	ZIP code
Other residence (if any): Street address	City	County	State	ZIP code
Home telephone number		Day telephone number		

Section B: Dependent information

Please list your incapacitated dependent.

First name Last name			Social security number
Relationship	Sex ☐ Male ☐ Female	Birth date	Date condition developed (MM/DD/YY)
Diagnosis			

Section C: Medicare information

Is the dependent entitled to Medicare as a result of this condition? ☐ Yes ☐ No

Section D: Other insurance

Is the dependent currently covered by health insurance other than this BCBSM/BCN plan or Medicare?
☐ Yes ☐ No If yes, please complete below.

Name of insured		Insurance company name	
Insurance company address: Street / P.O. Box number		City	State	ZIP code
Group or policy number	Contract type ☐ Single ☐ Family	Policy effective date (MM/DD/YY)	

Section E: Additional information

I am requesting that the dependent listed above be included under my coverage through the State of Michigan. I understand that this dependent may be covered under my coverage if:

- My dependent is incapable of self-support because of a physical or mental incapacity that existed prior to the end of the month he/she turned at 26.
- My dependent relies on me for support and maintenance.

I certify that I have read the entire application. I also certify that the statements and answers given are complete and correct to the best of my knowledge. I have provided supportive documentation on my dependent's disability as requested above and am aware that without proper documentation coverage may be denied. I am also aware that additional information may be required to make a determination of coverage, and that presenting this documentation does not imply automatic coverage.

Signature: _____ Date: _____

Section G: Dependent's attending Physician Certification (Completed by physician)

Date of first examination	Date of last examination	Frequency of visits

Diagnosis / Disability (Include ICD-10 Code)

Clinical information: (Medical summary documenting all items listed can be attached to form in lieu of completing this section)

Onset (specify date)

Test or data establishing diagnosis

Other medical problems

Current medications and treatment plan (Include expected duration)

Is this a psychiatric disability? If yes, please complete this section and address these items in your narrative report.
Complete DSMTV diagnosis required with descriptors, codes and severity specifiers:

☐ Axis I ☐ Axis II ☐ Axis III ☐ Axis IV ☐ Axis V GAF, current _____

GAF, highest, past year _____

Is the dependent able to independently manage his or her own finances? ☐ No ☐ Yes

Is the dependent fully compliant with treatment? ☐ No ☐ Yes

If no, please explain: _____

Would the prognosis be different if the dependent were compliant? ☐ No ☐ Yes

Has the dependent been hospitalized for a psychiatric condition? ☐ No ☐ Yes

Dates and facility: _____

What is the nature and degree of the dependent's impairment in their capacities for:

Daily activities? _____

Task performance? _____

Social interaction? _____

If disability involves developmental delay or intellectual deterioration, has IQ testing been performed?

☐ No ☐ Yes Results: _____ Date performed: _____

If not, what intellectual functions can be performed, (e.g., math, reading, comprehension, memory skills) _____

Is the dependent: ☐ Ambulatory ☐ Non ambulatory ☐ Bed confined ☐ Wheelchair confined

☐ House confined ☐ Hospital/Institution confined - Facility name _____

Prognosis of totally disabling condition:

☐ Permanent and total _____ Permanent and partial (%)

☐ Temporarily disabled with expected return to full function (%) Return date: _____

☐ Temporarily disabled with expected return to partial function (%) Return date: _____

Is the dependent capable of supporting himself/herself through gainful employment? ☐ No ☐ Yes

Section H: Verification

I certify that the above statements are relative to the disabled dependent named on the reverse side are true and complete to the best of my knowledge and belief.

Physician's name	Physician's specialty	License number

Physician's address

Signature: _____ Date: _____