Blue Cross Blue Shield Blue Care Network of Michigan

Disabled Dependent Application for State Health Plan (BCBSM) and Blue Care Network members

Guidelines and instructions

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

Disabled dependents are unable to earn a living because of a developmental or physical disability, and must depend on their parents for support and maintenance. State guidelines for incapacitated consideration differ between employees and retirees, as shown below.

Disabled dependent (definition for employees, based on the State of Michigan's plan requirements)

Incapacitated children of State of Michigan employees 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 children guidelines for employees, please visit http://www.michigan.gov/employeebenefits.

Disabled dependent (definition for retirees, based on the State of Michigan's plan requirements)

Incapacitated children of State of Michigan retirees are those who are totally and permanently incapacitated due to mental or physical disability. For more information on incapacitated children guidelines for retirees, please visit http://www.michigan.gov/ors.

For questions about incapacitated eligibility, please call the Employee Benefits Division at 1-800-505-5011.

Application instructions

If your child meets these guidelines, please complete and sign page 2 of this application.
Your child's physician must complete and sign page 3 of this application.
Note: If you're applying for more than one dependent (for example, to apply for twins), you must complete and mail a separate application for each child.

Send the completed application to:
Blue Cross Blue Shield of Michigan
Key State Accounts - State of Michigan Marketing Unit
600 E. Lafayette Blvd.
Detroit, MI 48226
ATTN: Senior Medical Analyst – MC G402
To send by fax: 1-866-392-2980

Once we receive your application, we'll review and determine if your child can continue under your health coverage as an incapacitated dependent. If your child does not meet the guidelines above, they will be considered ineligible and will be removed from your coverage.

Questions regarding this application?

State Health Plan (BCBSM) members call 1-800-843-4876

Blue Care Network members call 1-800-662-6667

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Please complete online, print form and mail to the address on the next 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

Section F: Verification

I am requesting that the dependent listed above be included under my coverage through the State of Michigan.

- 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 age 26.
- My dependent relies on me for support and maintenance I understand that this dependent may be covered under my coverage if:

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.

Subscriber's signature (do not print) _____ Date signed _____

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

Date of first examination	Date of last examination	Frequency of visits

Diagnosis/Disability (Include ICD10 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 III ☐ Axis V GAF, current _____
☐ Axis II ☐ Axis IV 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: _____

Send this completed application and any supporting documentation to:
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