APPLICATION TO CONTINUE COVERAGE FOR HANDICAPPED DEPENDENT CHILD

Certification of Attending Physician

(must be completed by attending physician)

Note: Any fee for the completion of this form is the responsibility of the member

Physician's Name _____ **Degree/Specialty** _____

Address _____ **Phone** _____

_____

_____

1. **The noted patient is presently under my care** _____ **Yes** _____ **No**
2. **Date Dependent was last treated** _____
3. **Diagnosis and concurrent conditions** _____

   _____

   _____
4. **Has such disability existed continuously since before Dependent attained age 19?** ___ **Yes** ___ **No**
5. **Has Dependent been confined in a hospital as a result of this disability?** _____ **Yes** _____ **No**

   If yes, give name and address of hospital _____

   _____

   Date Admitted _____ **Date Released** _____
6. **Nature of treatment:**
   - **A. Medication - i.e. dosage, frequency** _____

     _____
   - **B. Care Plan** _____

     _____
   - **C. Compliance with Prescribed Treatment**

     _____ **Good** _____ **Fair** _____ **Poor**
7. **Prognosis:**

   Is dependent totally disabled and incapable of self support? _____ **Yes** _____ **No**

   If not totally disabled, is dependent capable of self support? _____ **Yes** _____ **No**

   Do you expect a fundamental or marked change in the dependent's condition in the future?

   _____ **Yes** _____ **No**

   If yes, when will the patient recover sufficiently to be capable of self support?

   _____

   If no, please explain: _____

   _____
8. **Additional Remarks:** _____

   _____

   _____

Signature _____ **Date Signed** _____

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Member Name _____ **Identification No.** _____

Street Address _____ **Employer's Name** _____

City _____**State** _____ **Zip** _____ **Employer's Address** _____

_____

I HEREBY APPLY FOR CONTINUATION OF COVERAGE FOR THE FOLLOWING CHILD UNDER MY SUBSCRIPTION AGREEMENT(S):

Name of Dependent _____ **Birthdate** _____

Relationship to Member _____ **Is Dependent Married?** _____ **Yes** _____ **No**

Is the Dependent:
a. Receiving Benefits _____ **Yes** _____ **No**
b. Covered by Medicare _____ **Yes** _____ **No**
c. Receiving Social Security Benefits _____ **Yes** _____ **No**

If your dependent is presently enrolled under his/her own AmeriHealth Agreement,. give:
Id # _____ **Group Plan** _____ **Location** _____

I hereby certify that the above child is unmarried, is incapable of self-support, is in fact dependent upon me for over half of his or her support and that my child's disability commenced prior to attaining 19 years of age.

I understand and agree as follows: That the requested coverage for the above child shall not become effective unless and until this application is accepted and approved by AmeriHealth and thereafter may be revoked by AmeriHealth if any of the statements made herein are incorrect or if AmeriHealth later determines that the above dependent no longer qualifies for coverage as a handicapped dependent; That this application will become a part of my original application and will be subject to the terms of my subscription agreement(s); and; That acceptance of this application does not confer eligibility upon the above child for Major Medical benefits unless the group agreement describing the Major Medical Program so stipulates.

I further understand and agree that AmeriHealth reserves the right to request additional documentation if required.

Signature _____ **Date Signed** _____