DELTA DENTAL
Northeast Delta Dental

LGC HealthTrust

Anthem

P.O. BOX 617, CONCORD, NEW HAMPSHIRE 03302-0617
800.527.5001 • FAX 603.226.2988 • WWW.NHLGC.ORG

Request for Certification for a Mentally or Physically Incapacitated Dependent Child

Important: If you are transferring from another insurance carrier and the child is over nineteen (19) years of age written documentation is required from your prior carrier which states that:

- Dependent child was covered on a continual basis
- Coverage was in effect up to the date of insured's New Hampshire Local Government Center (LGC) HealthTrust coverage.

Section 1 – Subscriber and Dependent Child Information:

Name of Subscriber:	Street Address:	City:	State / Zip:
Subscriber's Identification Number:	Name of Employer:	Group Number:	
Name of Dependent Child to be Covered:	Street Address if Different:	City:	State / Zip:
Dependent Child's Birth Date: Month Day Year	Dependent Child's Social Security Number*:	Dependent Child's Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	

*Required by federal Medicare Secondary Payor laws

Is the Dependent Child employed for wages? ❑ No ❑ Yes
If yes, give name of employer and approximate number of hours worked per week:
Employer Name: ______________________ Number of Hours Worked: ______________

Is the Dependent Child confined to an institution or attending school? ❑ No ❑ Yes
If yes, give name of institution or school and date of admission:
Name of Institution or School: ______________________ Date of Admission: ______________

Is the Dependent Child receiving Medicare benefits? ❑ No ❑ Yes
If yes, include copy of Medicare card or SSI benefits with request form.

Is the Dependent Child receiving Medicaid benefits? ❑ No ❑ Yes
If yes, include copy of Medicaid card with request form.

Has the Dependent Child applied for SSI benefits? ❑ No ❑ Yes Date of Application:______________

What is the length of time this disability has existed? ______________ Start Date: ______________

Section 2 – Parent or Legal Guardian Signature:

I am requesting that the above-mentioned Child be included under my LGC HealthTrust membership.
I understand that this Child may be covered under my membership only so long as:

- The Child is incapable of self-support because of a physical or mental incapacity which existed prior to age 19, and
- I furnish more than one-half of this Child's support.

I further understand that:

- It is my responsibility to notify LGC HealthTrust of any change in the status of the Dependent Child's incapacity, and that
- Anthem Blue Cross and Blue Shield/LGC HealthTrust shall have the right to require recertification as to the eligibility for continuation of coverage as an incapacitated Dependent Child.

If you have additional questions or need assistance in completing this form, please contact your group's Benefits Administrator or LGC HealthTrust Member Services at 800.527.5001.

The information I have supplied above is true, and to the best of my knowledge, correct.

I hereby authorize any physician, other health care provider or facility that has diagnosed or rendered treatment for the above-named dependent to furnish Anthem Blue Cross and Blue Shield, full information, including copies of medical records, relating to such diagnosis or treatment. I certify that the above statements are true and complete to the best of my knowledge and belief.

Subscriber Signature: ______________________________ Date: ______________

Before you return the request form, have you:

❑ Completed and verified all information and sections of this request form?
❑ Read and signed section 2?
❑ Read and understood all sections?
❑ Submitted this form to the Dependent Child's Attending Physician for completion and signature?
❑ If Dependent Child is over 19 years of age and you are transferring from another insurance carrier, have you supplied written documentation of prior coverage up to the effective date of LGC HealthTrust coverage?

Please return form to: NH Local Government Center HealthTrust, P.O. Box 617, Concord, NH 03302-0617. **Questions?** Call LGC HealthTrust Member Services at 800.527.5001.

Section 3 – Child's Attending Physician Certification (TO BE COMPLETED BY PHYSICIAN):

Date of First Examination:_____/_____/_____ Date of Last Examination:_____/_____/_____ Frequency of Visits: ______________________

(must be within one year to consider this request)

Diagnosis/Disability (include ICD9 Code – required): ____

Clinical Information:

Medical summary documenting all items listed can be attached to form in lieu of completing this section.

Onset (specify date):_____/_____/_____

Test/Data Establishing Diagnosis: ____

____

____

Pertinent Clinical Findings and Course (including recent lab data): ____

____

____

Other Medical Problems: ____

Current Medications: ____

Treatment Plan (include expected duration): ____

____

____

If the disability is psychiatric, please complete this section also (or 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 Child financially competent? ❑ No ❑ Yes Is the Dependent Child fully compliant with treatment? ❑ No ❑ Yes If non-compliant, how not? ____________________ If not, might the prognosis be different if he/she were compliant? ❑ No ❑ Yes Has the Dependent Child been hospitalized for a psychiatric condition? Dates and facility: ____________________ What is the nature and degree of the Dependent Child's impairment in his/her capacities for: daily activities? ____________________ task performances? ____________________ 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: ____

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

Prognosis of Totally Disabling Condition:

❑ Permanent and Total ❑ Permanent and Partial (%)

❑ Temporarily Disabled with Expected Return to Partial Function (%) *Return* Date: ________________

❑ Temporarily Disabled with Expected Return to Full Function (5) *Return* Date: ________________

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

Signature: ____ Date: ________________

Physician's Name: ____

Physician's Specialty: ____

Physician's Address: ____

____

License Number: ____

Do not write in this space – office use only