Adult Disabled Dependent Initial Certification Form

Email or fax this form to:
Attn: Evry Health – Eligibility Department
Email: support@evryhealth.com
Fax: (325) 603-0541

Instructions for Completing the Adult Disabled Dependent Initial Certification Form

Completion of this certification is required for dependents that are coming upon the limiting age and need benefits to continue due to a physical or mental disability. To determine if your dependent qualifies for the Disabled Dependent Benefit, completion of this form by the member and treating medical provider is required.

Instructions

1. **Member Statement Pages:** Sections I, II, III, and IV to be completed in their entirety by the employee. **Member** is required to sign and date in Section IV. Member Confirmation, Signature and Date.
2. Member to provide an Active/Current copy of the "order(s)" (*guardianship, conservatorship, court order, divorce decree)* employee has in place for the dependent if circled in Section II, Dependent Information and/or an active/current copy of the SSDI/SSI benefit statement if "Yes" was circled in Section III, Question 5.
3. Member to provide a copy of the proof of prior coverage documents, if '**YES**' was circled in Section III, Question 2 - "Did the dependent have a loss of coverage?"
4. **Medical Provider Statement Page:** To be completed in its entirety by the treating medical provider. **Treating medical provider** is required to confirm, sign and date.
5. Confirm all pages of the certification form have been completed in their entirety **AND** make a copy for your files before returning the form. *(Omission of any information required will cause a delay in the processing of your request).*
6. Return all pages of the fully completed certification form and any additional documents to Evry Health at the email address or fax number shown above.

Upon completion of the review process, you and/or your employer group will receive a written confirmation advising of the review determination and coverage dates if applicable. Please allow up to 30 business days for review completion.

For any additional questions regarding your dependent child's eligibility benefits, please contact your employer's Human Resources Department for further assistance.

PRODUCT AVAILABILITY MAY VARY BY PLAN TYPE AND LOCATION AND IS SUBJECT TO CHANGE.
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Please read the following carefully: I certify that I have carefully and fully read the information on the next page of this form. I also certify that the statements and answers given are complete and correct to the best of my knowledge. No information required to be given, either expressly or by implication, has been knowingly withheld. I have provided supportive documentation on my dependent's disability as requested above and I 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. I agree to promptly advise Evry Health of any change that affects the adult dependent's eligibility in accordance with the terms of my Evry Health policy. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information, or who conceals, for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act. This may be a crime and I may be subject to a civil penalty.

Member Signature: _____

Date: _____

Please note member statement and provider statement form must be submitted together in entirety.

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Member's Statement	***Member to complete sections I, II, III, IV. Omitted information will cause delays.***		
Section I. Member Information			
Employer Name			
Member Name (First, Middle, Last)			
Marital Status □ Never Married □ Married □ Divorced □ Widowed □ Legally Separated			
Date of Birth (mm/dd/yyyy)	Member ID #	Relationship to Dependent	Home/Mobile Phone
Current Address	State	ZIP Code	
Mailing Address (if different):			
Email Address			
Section II. Dependent Information			
Select **all applicable** orders in place by Member regarding Dependent. □ Guardianship □ Court Order If checked, **submit an active/current** copy of each with this form. □ Conservatorship □ Divorce Decree			
Dependent Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy)		
Marital Status □ Never Married □ Married □ Divorced □ Widowed □ Legally Separated			
Does the dependent live in your household? □ **Yes** □ **No**			
If NO, provide reason for different residing address than employee below. (Example: Lives in a group home, medical facility, etc.)			
Currently Resides at (Street, City, State, Zip Code):			
Mailing Address (if different):			
Section III. Financial and Dependent Employment Information			
For employees with a new employer: 1. Was dependent covered under your prior employer's insurance plan? □ **Yes** □ **No** □ **Not Applicable**			
1a. If YES, provide coverage dates. From (mm/dd/yyyy): To (mm/dd/yyyy):			
1b. If NO, please explain.			
2. Did the dependent have a loss of coverage? □ **Yes** □ **No** □ **Not Applicable**			
2a. If YES, Submit a copy / proof of prior coverage AND answer coverage questions below:			
Prior insurance carrier:			
Subscriber's name:			
Group name:			
Coverage dates: From (mm/dd/yyyy): To (mm/dd/yyyy):			

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3. Does employee provide more than 50% of the dependent's support & maintenance*? □ **Yes** □ **No** *For example: food, medicine/prescriptions, utility, housing, etc.
4. On what date was the dependent last claimed on your federal personal income tax return? Date last claimed (mm/dd/yyyy):
4a. Provide further explanation below.
5. Does dependent receive SSDI/SSI benefits? □ **Yes** □ **No**
5a. If YES, amount per month $ **AND** submit a copy of current SSDI/SSI benefit statement.
6. Is dependent currently working? □ Full Time □ Part Time □ Currently Not Working
6a. If dependent is NOT currently working, date last employed (mm/dd/yyyy): 6b. If dependent is currently working, gross monthly income (before taxes) $_____ 6c. Is dependent's current position with employer eligible for health insurance? □ **Yes** □ **No**
6c-1. If answered YES, above in 6c, is dependent carrying "own" health insurance? □ **Yes** □ **No**
6c-1a. If answered NO, above in 6c-1, provide explanation as to why dependent is not carrying "own" coverage.
6d. Provide name and address of dependent's current employer below: (Street, City, State, Zip Code)
7. Is dependent currently a student in post-secondary schooling? □ **Yes** □ **No**
7a. What is the highest grade/level of schooling completed? Enrolled: □ Full-Time □ Part-Time Grade/Level: School type:
8. Does dependent hold a valid driver's license? □ **Yes** □ **No**
9. Provide any further explanations/additional information: (attach additional pages if needed)

Section IV. Member Confirmation, Signature and Date	
I confirm I have completed the Member's Statement in its entirety. I know it is a crime to fill out this form with information I know is false or leave out information I know is important.	
Member's Signature	Date (mm/dd/yyyy)

THIS PAGE TO BE COMPLETED BY THE DEPENDENT'S TREATING MEDICAL PROVIDER ONLY

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Medical Provider Statement

Medical provider statement. Any fee for the completion of this statement is to be paid by the member.
Answer all questions below. Omitted information will cause delays.

Patient's Name (First, Middle, Last)	Patient's Date of Birth (mm/dd/yyyy)

1. What is the primary disabling diagnosis?

2. Age diagnosed with primary disabling diagnosis:
□ From birth □ From _____years of age

3. The patient is presently: (Check all applicable)
□ Ambulatory Confined To: □ Bed □ House
□ Hospital □ Wheelchair

4. What are the physical/mental/functional limitations related to the primary disabling diagnosis?

5. Are there any other diagnoses currently being treated? □ **Yes** □ **No**

5a. If YES, please list:

6. Is patient currently able to work? □ **Yes** □ **No**	6a. If yes, select one: □ **Full Time** □ **Part Time**

7. Is patient currently able to be self-supportive [does not need financial help from others]? □ **Yes** □ **No**

7a. Is patient currently physically able to care for self? □ **Yes** □ **No**

8. Will patient be capable of self-support in the future? □ **Yes** □ **No**	8a. If yes, as of what date (mm/dd/yyyy):

9. If you answered NO to Questions 6-8 above, please explain below. (select all applicable)
□ Intellectual/Developmental Disability □ Physical Handicap □ Mental Handicap □ Other (Explain below)

[ ] Documents Attached. Current written documentation or medical records (within the last three (3) months).

Provider Confirmation, Signature and Date

I confirm I have completed the Medical Provider Statement in its entirety. I know it is a crime to fill out this form with information I know is false or to leave out information I know is important.

Provider's Signature	Date (mm/dd/yyyy)
Medical Provider Address (street, city, state, zip code)	Provider Phone:

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