Adult Disabled Dependent Continued Coverage Request Form

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

Instructions for Completing the Adult Disabled Dependent Continued Coverage Request Form

Please complete this form to request continued coverage for a disabled adult dependent age 26 or above. Completed paperwork is required withing 31 days of your dependent reaching the age of 26. Additionally, a recertification of disability may be required annually to ensure ongoing coverage.

Instructions

1. **Member Statement Pages:** Sections I, II, and III to be completed in their entirety by the employee.
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 II, Question 5.
3. **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.
4. 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).*
5. 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.
ALL GROUP HEALTH INSURANCE POLICIES AND HEALTH BENEFIT PLANS CONTAIN EXCLUSIONS AND LIMITATIONS.

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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. Omitted information will cause delays.***
Section I. Member Information					
ID Number (if already enrolled)	Name (First, Middle Initial, Last)			Social Security Number	
Street Address	Apt/Floor	City	State	Zip Code	
Phone Number	Email Address				
Section II. Dependent Information					
Select **all applicable** orders in place by Member regarding Dependent. If checked, **submit an active/current** copy of each with this form.			□ Guardianship □ Conservatorship	□ Court Order □ Divorce Decree	
Dependent Name (First, Middle, Last)	Date of Birth			Social Security Number	
Dependent relationship to Subscriber ☐ Child ☐ Other (specify)					
The dependent listed above is the unmarried child, stepchild or adoptive child of the subscriber and is age 26 or older.				☐ Yes ☐ No	
The dependent listed above resides with me or my spouse.				☐ Yes ☐ No	
Has the dependent ever been employed for wages? Currently working at /worked in the past at Hours per week Wages per week				☐ Yes ☐ No	
Is the dependent eligible for care under Medicare?				☐ Yes ☐ No	
Has the dependent been found eligible as disabled by Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)? If yes, documentation is required to evaluate disabled dependent coverage. Example: Notice of award letter.				☐ Yes ☐ No	
Section III. 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)	

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

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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