BlueCross BlueShield of Texas

Disabled Dependent Authorization

P.O. Box 660044 Dallas, TX 75266-0044
Fax: 312-946-3541

1. NAME OF POLICYHOLDER (PRINT – LAST, FIRST & MIDDLE INITIAL)	1A. BLUE CROSS AND BLUE SHIELD OF TEXAS NUMBERS GROUP NUMBER: MEMBER ID NUMBER:
2. POLICYHOLDER'S ADDRESS (NUMBER, STREET, CITY, STATE & ZIP CODE)	

3. DEPENDENT'S NAME	3A. DEPENDENT'S BIRTHDATE (MM/DD/YYYY) / /	3B. DEPENDENT'S MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
3C. DEPENDENT'S RELATIONSHIP TO POLICYHOLDER	3D. DEPENDENT'S SEX ☐ MALE ☐ FEMALE	3E. DEPENDENT'S AGE WHEN DISABILITY OCCURRED _____

4. IS DEPENDENT PERMANENTLY RESIDING IN YOUR HOUSEHOLD? IF **NO**, PLEASE EXPLAIN. IF ADDITIONAL SPACE IS NEEDED USE AN ADDITIONAL SHEET OF PAPER. _____ _____ _____	☐ YES ☐ NO
5. IS THIS PERSON DEPENDENT UPON YOU FOR SUPPORT? IF **YES,** WHAT PERCENTAGE OF SUPPORT DO YOU CONTRIBUTE? _____ %	☐ YES ☐ NO
5A. IS DEPENDENT LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN?	☐ YES ☐ NO
6. WAS DEPENDENT EVER EMPLOYED?	☐ YES ☐ NO
6A. IS DEPENDENT NOW EMPLOYED?	☐ YES ☐ NO
7. WAS DEPENDENT COVERED UNDER YOUR PRESENT EMPLOYER'S INSURANCE PROGRAM IMMEDIATELY PRIOR TO REACHING AGE 26?	☐ YES ☐ NO
8. IS DEPENDENT NOW COVERED UNDER MEDICARE OR ANY OTHER HOSPITAL-MEDICAL COVERAGE? IF **YES,** FURNISH NAME OF INSURANCE COMPANY AND GROUP, CERTIFICATE OR AGREEMENT NUMBER. INSURANCE COMPANY _____ GROUP, CERTIFICATE OR AGREEMENT NUMBER_____	☐ YES ☐ NO

When I provide an original or copy of this signed form, I am allowing any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide Blue Cross and Blue Shield of Texas (BCBSTX) with information. This may include copies of records concerning advice, care or treatment provided to the dependent named above, including, without limitation, information relating to mental illness, use of drugs or alcohol.

I understand that such information will be used by BCBSTX for the purpose of certifying the above named dependent as disabled for purpose of coverage under my health insurance. I understand that I or any other authorized representative will receive a copy of this authorization upon request. This authorization to collect medical information is valid from the date signed for a period of two and one-half years.

I certify that the above information is correct to the best of my knowledge and belief.

Signature of Policyholder: X _____ **Date Signed:** _____

BlueCross BlueShield of Texas

P.O. Box 660044 Dallas, TX 75266-0044
Fax: 312-946-3541

Disabled Dependent Physician Certification

To: Attending Physician

CLAIM NUMBER:	PATIENT NAME:	INSURED NUMBER:
SERVICE DATE: (MM/DD/YYYY) / /	PROVIDER NAME:	DIAGNOSIS CODE:

NOTE: Any fee for the completion of this form is the responsibility of the policyholder.

1. IS DEPENDENT NOW INCAPABLE OF SELF-SUPPORT BECAUSE OF DISABILITY?	☐ YES ☐ NO
2. FROM WHAT AGE HAS SUCH DISABILITY EXISTED CONTINUOUSLY?	☐ FROM BIRTH ☐ FROM AGE _____

3. NATURE OF DISABILITY (PLEASE BE AS SPECIFIC AS POSSIBLE. OTHERWISE, IT MAY BE NECESSARY TO CONTACT YOU FOR MORE DETAILS.) INCLUDE PAST AND CURRENT MEDICAL TREATMENT PLANS. IF ADDITIONAL SPACE IS NEEDED USE AN ADDITIONAL SHEET OF PAPER OR ATTACH COPIES OF MEDICAL RECORDS/PROGRESS NOTES IF APPLICABLE.

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. PROGNOSIS:

_____

_____

_____

_____

_____

Name of Physician (Print or Type) _____ **Degree**_____

Physician's Signature: _____ **Date Signed:** _____