



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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
3c. Dependent's Relationship to Policyholder	3d. Dependent's Sex <input type="checkbox"/> Male <input type="checkbox"/> 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 the back of the form. _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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5. Is this person dependent upon you for support? If Yes , what percentage of support do you contribute? _____ %	<input type="checkbox"/> Yes <input type="checkbox"/> No
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5a. Is dependent listed as a dependent on your last Federal income tax return?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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6. Was dependent ever employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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6a. Is dependent now employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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7. Was dependent covered under your present employer's insurance program immediately prior to reaching age 26?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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), a Division of Health Care Service Corporation, 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 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:** ____/____/____

Disabled Dependent Physician Certification

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

To: Attending Physician

Claim Number:	Patient Name:	Insured Number:
Service Date: / /	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. From what age has such disability existed continuously?	<input type="checkbox"/> From Birth <input type="checkbox"/> 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 the back of the form or attach copies of medical records/progress notes if applicable.	
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4. Prognosis:	
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Name of Physician (Print or Type) _____ **Degree** _____

Physician's Signature: X _____ **Date Signed:** ____/____/____