

# Handicapped Dependent Certification



Please fill in all sections completely and submit to:

Esubmit: <https://global.acswellpoint.com/Esubmit/>

Mail: Anthem Blue Cross  
P.O. Box 9062  
Oxnard, CA 93031

Fax: 1-855-750-2227

## Section 1: Contract holder

Last name	First name	M.I.	ID no.
Street address	City	State	ZIP code
Phone no.	Employer name	Group no.	

## Section 2: Dependent

Last name	First name	M.I.	Date of birth (MM/DD/YYYY)
Social Security no.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single	Relationship to contract holder
Type of disability			Date of disability (MM/DD/YYYY)
Does the contract holder claim the dependent for income tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the dependent live with the contract holder? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "No" to either question, please explain: _____			

## Section 3: Other insurance policies for this dependent

Does the dependent currently have other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the next two rows.			
Insurance company name	Address		
Contract holder name	Policy no.	Effective date (MM/DD/YYYY)	
Will this policy replace other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the next two rows.			
Insurance company name	Address		
Contract holder name	Policy no.	Effective date (MM/DD/YYYY)	Cancellation date (MM/DD/YYYY)
Is the dependent currently receiving Social Security benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," what was the effective date? _____ (MM/DD/YYYY)		If "No," have benefits been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.</b>			
Signature of contract holder <b>X</b>			Date (MM/DD/YYYY)

## Section 4: Diagnosis/Prognosis – Must be completed and certified by a physician

Diagnosis	ICD-10 code(s)		
In your opinion, is the above named dependent currently incapable of self-sustained employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In your opinion, will the dependent ever be capable of self-sustained employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," provide estimated date of return to full functionality: _____ (MM/DD/YYYY)			
Physician name	Physician signature <b>X</b>	Date (MM/DD/YYYY)	
Physician street address	City	State	ZIP code