

Handicapped Dependent Certification



Please fill in all sections completely and mail to:

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

You may also fax to 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? _____			If "No," have benefits been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.						
Signature of contract holder X					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 X		Date (MM/DD/YYYY)	
Physician street address			City		State	ZIP code