PHYSICIAN FORM FOR HANDICAPPED DEPENDENT

MR Type- for internal use only

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME	
SUBSCRIBER'S ADDRESS Street: City: State: Zip Code:			
NAME OF HEALTH PLAN:		HEALTHPLAN CODE:	ID NUMBER
GROUP NAME			GROUP/DIVISION NUMBER

Please respond to the questions below in as complete a manner as possible. This information will assist CIGNA HealthCare in determining this patient's eligibility for continued health care coverage as a handicapped dependent.

To Identify the Treating Physician:

Physician Name:

Specialty:

License Number:

Address:

Telephone Number:

Fax Number:

Diagnosis(es) (ICD-9) _____, _____, _____, _____

1. How long have you treated this patient and when did you last see him/her?

2. What is the degree of physical/mental impairment?

Please complete this form on the reverse side

3. In your professional opinion, is this patient continuously incapable of self-sustaining employment due to a physical or mental handicap? ☐ Yes ☐ No
If yes, please explain.

4. How long has this patient been incapable of self-sustaining employment? (Please answer this question based upon your understanding of the patient's medical history.)

5. When, in your professional opinion, might this patient be capable of self-sustaining employment?

6. Is the individual trainable/educable?

Physician's Signature _____ Date _____

Physician Printed Name: _____

Please mail this form to: CIGNA HealthCare at the address listed on the back of the member's CIGNA ID card or to: CIGNA HealthCare
P.O. Box 22170
Tempe, AZ 85285-2170

Questionnaire for Verification of Handicapped Adult Dependent Eligibility

CIGNA HealthCare

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME	
SUBSCRIBER'S ADDRESS Street:	City:	State:	Zip Code:
NAME OF HEALTH PLAN:	HEALTHPLAN CODE:	ID NUMBER	
GROUP NAME		GROUP/DIVISION NUMBER	

Please complete sign/date this Questionnaire.

Please return the Questionnaire with the appropriate documentation in the enclosed window envelope.

Please make sure the return address appears in the window.

CIGNA HealthCare
PO BOX 5750
Scranton, PA 18505

Handicap/Disabled Dependent Verification

Is this Dependent:

- Your natural child, step-child, or adopted child or a child that a court has ordered you to support? ☐ Yes ☐ No
- Your grandchild? ☐ Yes ☐ No
- Married? ☐ Yes ☐ No
- Primarily dependent on you for support or legally dependent on you for support? ☐ Yes ☐ No
- Continuously incapable of self-sustaining employment as a result of a mental or physical handicap? ☐ Yes ☐ No

  Please describe the mental or physical handicap:

When did this handicap become severe enough to prohibit self-sustaining employment:

- Before your child reached the limiting age for a dependent under your plan? ☐ Yes ☐ No
- While your child was covered as a full-time student? ☐ Yes ☐ No

Please return this entire Questionnaire with the enclosed Physician Form completed by the attending physician.

Verification of dependent eligibility may be requested periodically.

I, _____, hereby certify, under penalty of perjury, that:
(Your Name)

1. I am over eighteen years of age and understand the obligations of an oath.
2. The information provided above is true and complete to the best of my knowledge.
3. I understand that if I misrepresent or provide false or incomplete information, my membership may be terminated (including retroactively) at the discretion of CIGNA HealthCare and/or my employer.

Employee Signature: _____

Printed Name: _____

Date: _____