

Request for Certification of Incapacitated Dependent

Please complete form, attach any necessary documentation, and return to the address below.

HealthSmart Benefit Solutions ■ P.O. Box 99004 ■ Anchorage, AK 99509-9004

Toll Free 877.517.6370 ■ Fax 855-328-5176

Please include all documentation of Social Security benefits, guardianship and a copy of your tax return claiming this dependent.

Member Information

Name (First, Initial, Last)		Member ID (Required)	
Street Address		City	State ZIP
Employer	Group Number		
AlaskaCare	<input type="radio"/> Actives <input type="radio"/> Retirees		

Dependent's Information

Dependent's Name		Relationship to Employee:	
Birth Date		Marital Status:	
/ /		<input type="radio"/> Son <input type="radio"/> Daughter <input type="radio"/> Other (explain): <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced	
Is this dependent covered by Medicare?		Dependent's Social Security Number	
<input type="radio"/> No <input type="radio"/> Yes			
Do you support this dependent?		Does this dependent reside with you?	
<input type="radio"/> No <input type="radio"/> Yes If yes, what amount? %		<input type="radio"/> No <input type="radio"/> Yes If no, why?	
Dependent address if different than member		City	State ZIP
Is this dependent chiefly dependent on you for support and maintenance?		If this dependent is 19 or older, has a court appointed you his/her legal guardian?	
<input type="radio"/> No <input type="radio"/> Yes		<input type="radio"/> No <input type="radio"/> Yes If Yes, please attach a copy of court documentation.	
Has this dependent ever been employed?		Now employed?	
<input type="radio"/> No <input type="radio"/> Yes		<input type="radio"/> No <input type="radio"/> Yes	

Please provide dependent's employment information (use additional sheet of paper if necessary). Provide a description of both current and chronic specific symptoms and functional impairments that render the individual incapable of self-sustaining employment and a clear explanation of how those symptoms and functional impairments in fact render the individual unable to sustain employment.

Employer's Name	Employer's Address	Position Held	Dates of Employment
1.			
2.			

Member's Signature. I certify that this information is correct to the best of my knowledge.

Date signed

X	/ /
----------	-----

Physician—Complete Below

Any fee for the completion of this form is the responsibility of the subscriber.

Physician Name		Degree	
Street Address		City	State ZIP
Is dependent above incapable of self-sustaining employment due to disability?			
<input type="radio"/> No <input type="radio"/> Yes			
Did the disability exist before the dependent reached the plan's limiting age?			
<input type="radio"/> No <input type="radio"/> Yes			

Nature of Incapacitation

In an attached letter, please address the following items using as much detail as possible. Attach medical records pertaining to the disability within the past 12 months (to include the most recent complete physical, functional, and communicative evaluative documentation, laboratory and clinical findings).

ICD-9 Code(s) that is the handicapping condition:

Identify the current treatment for identified symptoms and functional impairments.

Is the disability

Temporary or Permanent?

If **Temporary**, what is the estimated time frame for the disability?

If **Permanent**, provide rationale for that status.

Provide a description of both current and chronic specific symptoms and functional impairments that render the individual incapable of self-sustaining employment and a clear explanation of how those symptoms and functional impairments in fact render the individual unable to sustain employment. If the individual is currently employed, please describe the job responsibilities and explain why this individual should be considered incapable of self-sustaining employment when he/she is in fact employed.

Physician Signature

Date signed

Date of last evaluation

X

/ /

/