Handicapped Dependent Certification

Anthem BlueCross

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	Marital status	Relationship to contract holder
	☐ Male ☐ Female	☐ Married ☐ Single	

Type of disability	Date of disability (MM/DD/YYYY)

Does the contract holder claim the dependent for income tax purposes? ☐ Yes ☐ No

Does the dependent live with the contract holder? ☐ Yes ☐ No

If "No" to either question, please explain: _____

Section 3: Other insurance policies for this dependent

Does the dependent currently have other insurance coverage? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

If "Yes," what was the effective date? _____ (MM/DD/YYYY) If "No," have benefits been denied? ☐ Yes ☐ 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	Date (MM/DD/YYYY)
X	

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? ☐ Yes ☐ No

In your opinion, will the dependent ever be capable of self-sustained employment? ☐ Yes ☐ No

If "Yes," provide estimated date of return to full functionality: _____ (MM/DD/YYYY)

Physician name	Physician signature	Date (MM/DD/YYYY)
	X	

Physician street address	City	State	ZIP code

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