

Commonwealth of Virginia Adult Incapacitated Dependent Certification Form



Important Notice: To request continued coverage for your dependent child as an adult incapacitated dependent (AID) under the Commonwealth of Virginia Health Benefits Program, you must complete Part A of the adult incapacitated dependent form. Your dependent's physician must complete Part B of the form. Upon completion, the form must be returned to Barbara Muse, Anthem Blue Cross and Blue Shield, Commonwealth of Virginia Member Services, P.O. Box 27401, Maildrop VA1004-S121, Richmond, VA 23279, fax 1-804-354-4775 or email barbara.muse@anthem.com. If the form is not received by the end of the calendar year, coverage will end for your dependent January 1st of the following year. Please feel free to contact Anthem Member Services at 1-800-552-2682 if you have questions.

Section 1: Employee/Retiree

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

Section 2: Adult Incapacitated Dependent (AID)

Last name		First name		M.I.	Date of birth (MM/DD/YYYY)
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single		Relationship to contract holder		
Do you provide over one half of the AID's support? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the AID live full-time with the employee/retiree as a member of your household? (If the natural or adoptive parents live apart, living with the other parent will satisfy this requirement.) <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "No", does the AID live in a facility? Please select one: <input type="checkbox"/> Group Home <input type="checkbox"/> Nursing Home/Convalescent Home <input type="checkbox"/> Long-term Care Facility					
Name of Facility: _____ <input type="checkbox"/> Other, please be specific: _____					
Is the AID currently employed? If yes, provide a description of his/her employment; include if part-time, full-time. _____					

Section 3: Other insurance policies for this AID

Does the AID have Medicare, Medicaid, Employer Health Plan, other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the next two rows.			
Insured's Name/Contract Holder		Medicare/Medicaid/Employer Health Plan/Other	
Employee Name		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.			
Insured's Name/Contract Holder		Medicare/Medicaid/Employer Health Plan/Other	
Employee Name		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

Type of disability		Date of disability (MM/DD/YYYY)	
Diagnosis		ICD-10 code(s)	
What is the Prognosis? If disability isn't lifelong, please describe estimated number of months or years. _____			
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	
Physician street address		Date (MM/DD/YYYY)	
City		State	ZIP code