Blue Cross of Idaho®

Certification for a Totally Disabled Member

Instructions:

Answer each question completely. Failure to provide complete information will delay eligibility determination and determination of claims payment. Do not provide any genetic information when answering the questions below. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses will only be considered and applied to the individual in question.

Section 1: Member/Employee Information

Last name	First name		Blue Cross of Idaho ID no.
Address	City	State	ZIP code
Company/Employer name	Group no.	Member email address	

Do you claim this member on your Federal Income Tax? ❑ Yes ❑ No
1040 tax filing attached — 1040 tax filing information is required for processing. Forms will not be processed without this information.

Section 2: Disabled Member Information

Last name	First name	M.I.	Relationship
Date of birth (MM/DD/YYYY)	Social Security no.	Is the member currently married? ❑ Yes ❑ No	
Address, if different from the above	City	State	ZIP code

Section 3: Has the member ever been employed? — If yes, please complete this section.

Name of employer	Dates of employment (MM/YY)		Hours per week	Duties
	From	Through		

Section 4: Medicare/Medicaid Information

Is the above-named member receiving Medicaid/ Medicare benefits? ❑ Yes ❑ No If yes, please provide information	From	Through	Medicaid ID no.	Effective date

Medicare ID no.	Part A effective date	Part B effective date	Part D effective date

Section 5: Is disability due to accident or injury? — If yes, complete this section.

Accident/injury date	Where accident/injury occurred
How accident/injury occurred	

Section 6: Abilities and Limitations

Describe in detail member's limitations in performing daily activities and ability to manage his/her own affairs.

Daily activities
Task performance
Social interaction

3000 E. Pine Ave. • Meridian, Idaho 83642 • 208-345-4550
Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

Section 7: Authorization and Release of Information

I hereby authorize any physician, other health care provider or facility that has diagnosed or rendered treatment for the above-named member to furnish Blue Cross of Idaho full information, including copies of medical records, relating to such diagnosis or treatment. I certify that the above statements are true and complete to the best of my knowledge and belief.

Employee signature	Date
X	

FOR PHYSICIAN USE ONLY: To be completed by treating physician

Examination — Date of last examination must be within one year to be considered.

Disabled member name (last, first, M.I.)	Date of first examination	Date of last examination

Diagnosis/Disability	Frequency of visits

Clinical information — Please complete this section or attach medical summary documenting all items listed.

Onset of disabling condition (MM/YYYY)	Tests/Data establishing diagnosis

Pertinent clinical findings and course (including recent lab data)

Other medical problems

Current medications

Treatment plan (include expected duration)

Is the member financially competent? ❑ Yes ❑ No

Is the member fully compliant with treatment? ❑ Yes ❑ No If not, please explain

Might the prognosis below be different if he/she were compliant? ❑ Yes ❑ No

Has the member been hospitalized for this disabling condition? ❑ Yes ❑ No If yes, please complete below and attach any additional hospitalizations.

Facility	Dates
Facility	Dates

What is the nature and degree of the member's impairment in his/her capacities for:

Daily activities

Task performance

Social interaction

If disability involves developmental delay or intellectual deterioration, has IQ testing been performed? ❑ Yes ❑ No	Date performed

FOR PHYSICIAN USE ONLY: To be completed by treating physician *(Continued)*

Disabled member name (last, first, M.I.)
Results
Explain deficits in intellectual function (e.g. math, reading, comprehension, memory skills)

Is the member:	Ambulatory, House confined	Non-ambulatory, House confined	Non-ambulatory, Bed-confined	Wheelchair confined	Confined to an Institution

Is the member capable of supporting himself/herself through gainful employment? ❑ Yes ❑ No

Prognosis of totally disabling condition

Permanent and total	Permanent and partial _____%
Temporarily disabled with expected return to partial function _____%	Return date
Temporarily disabled with expected return to full function	Return date

If the disability is psychiatric, please complete this section (or address these items in your narrative report)

Complete DSMIV diagnosis required with descriptors, codes, and severity specifiers

Axis I		
Axis II		
Axis III		
Axis IV		
Axis V	GAF, current	
	GAF, highest, past year	

Physician's Signature and Information

I certify that the above statements relative to the disabled member named on this form are true and complete to the best of my knowledge and belief.

Physician signature X	Date
Physician's name	

Specialty	Phone no.

Address	City	State	ZIP code