

4510 13th Avenue South Fargo, North Dakota 58121

APPLICATION FOR DEPENDENT DISABILITY

BEN	IEFIT PLAN NUMBER			
Dep	endent's Name Social Security Number			
Med	licare ID Card Number			
Hosp	oital Part A Effective Date Medical Part B Effective Date Pres	cription Drug Pa	art D Effective Date	
			1	
SUE	BSCRIBER'S STATEMENT – to be completed by subscribe	r.		
1.	Does dependent reside at the home of the subscriber?		☐ Yes ☐ No	
	If not, why? (ie. divorce decree, group home, residential facility)			
	Address of dependent:			
2.	Is the dependent claimed on the subscriber's federal tax income return?		☐ Yes ☐ No	
3.	Is the dependent unmarried?		☐ Yes ☐ No	
4.	Is the dependent capable of ANY employment?		☐ Yes ☐ No	
	If yes, is the dependent employed?		☐ Yes ☐ No	
	Where?			
	Job Description:			
	Number of Hours per week:			
	Method of transportation to and from job (drives car, uses public transportation)	ortation, uses s	special van	
	(ie. "Handiwheels", etc)			
5.	Does dependent have a diagnosis of mental retardation?		☐ Yes ☐ No	
6.	Does dependent have a diagnosis of physical disability?		☐ Yes ☐ No	
7.	Does dependent have a diagnosis of any seizure disorder?		Yes No	
	If yes, when was the last seizure?			
	Medication, dose and frequency:			
	Number of seizures per day:			
8.	Does dependent attend school?		☐ Yes ☐ No	
	Where? V	Vhat grade lev	el?	
	Mainstream (in non special education class) experience:			
9.	Is dependent blind and/or deaf? Yes-Blind		f No	
	If yes, does/did the dependent attend special education for the disability?		☐ Yes ☐ No	
10.	Was the dependent born with the disability?		∐ Yes ∐ No	
11.	Was the disability acquired?		∐ Yes ∐ No	
	Where?	_ When?		
	How?			
12.	What is the dependent's level of activity for Activities of Daily Living (ADI	_'s)?		
	Needs complete assistance in feeding, dressing, etc.			
	Needs partial assistance in feeding, dressing, etc.			
	Needs mental cueing to do activity.			
	Needs assistance for mobility, does most ADL's independently (ie. ne	eds assist to w	heelchair, car, bed	
13.	What is the expected date of improvement in condition or recovery?			
	Disability is considered permanent.			
	Disability is of a nature that dependent status MIGHT change after su		_	
	Disability is of a nature that dependent status WILL change after su	fficient educat	ion, and training.	

PHYSICIAN STATEMENT – to be completed by the attending physician.

	his is to certify thatas the specific diagnosis(es) (ICD-9-CM)		
ПТ	This dependent is receiving the following medications:		
t	The disability is of a permanent nature (ie. anacephalic, quadriplegia, severe mental retardation) such that the dependent is incapable of self-support because of the mental retardation or physical disability This disability prevents him or her from engaging in ANY occupation or employment. (Be specific)		
	he disability is of a partial nature (ie. blind, deaf, educable mental retardation, etc.) Be specific)		
ПТ	here is potential for independent living with appropriate education at sometime in the future.		
I hereby a Blue Cros	authorize Doctor to complete this form and forward it to the ss Blue Shield of North Dakota office at 4510 13 th Avenue South, Fargo, North Dakota 58121.		
Subscrib	per Signature:		
Subscrib	per Address:		
Physicia	n Signature:		
Date:			