Request for Certification of Disabled Dependent

COMMON GROUND HEALTHCARE COOPERATIVE

Employee Instructions:

- Complete all sections on this form.
- Ask your physician to complete the attending physician's statement and return the form to you.
- **Return the completed form to CGHC**:

Fax: (262) 754-9560 Attn: Sales | **Mail:** CGHC Attn: Sales, PO Box 1630, Brookfield, WI 53008-1630 | **Email:** Sales@CommonGroundHealthcare.org

Employee Information

CGHC Member #	**CGHC Group #**	
Employee Name (last name, first name, M.I)		
Employee Address (including City, State, Zip Code)		
Dependent's Name	**Dependent's Birthdate**	**Dependent's Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Dependent's Relationship to Employee ☐ Daughter ☐ Son ☐ Other (explain):	**Dependent's Gender** ☐ Female ☐ Male	**Dependent's Age when Disability Occurred:**
A. Is this dependent covered by Medicare?	☐ Yes ☐ No	**If Yes, please list his/her SSN:**
B. Do you support this dependent?	☐ Yes ☐ No	**If Yes, what amount?** _____ %
C. Does this dependent reside with you?	☐ Yes ☐ No	**If No, why?**
D. Dependent address if different than subscriber: _____		
E. Does this dependent chiefly rely on you for support and maintenance?		☐ Yes ☐ No
F. If this dependent is 18 or older, has a court appointed you his/her legal guardian?	☐ Yes ☐ No	**If Yes, attach copy of documentation.**

I Certify that this information is correct to the best of my knowledge.

Policyholder Signature
X

Date Signed

Physician* - Complete Below

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

Physician Name		**Degree**	
Street Address	**City**	**State**	**ZIP Code**
A. Is dependent above incapable of self-sustaining employment due to disability?		☐ Yes ☐ No	

B. **Nature of Disability:** Please attach a letter to address the following items using as much detail as possible. Also 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 Code(s) that is/are the handicapping condition: _____
- Identify the current treatment for identified symptoms and functional impairments.
- Is the disability temporary or permanent? ☐ temporary ☐ permanent
  - If temporary, what is the estimated time frame for the disability? _____
  - If permanent, provide rationale for that status.
- Please provide a description of specific symptoms and functional impairments that render the individual disabled. Please also provide supporting documentation including your most recent medical history and physical exam notes (must be within the past 12 months); functional assessments such as activities of daily living, education/ employment capabilities, etc; results of any specialized testing including laboratory tests, functional capacity tests, neuropsychiatric tests, etc.; as well as treatment prescribed and prognosis.

Signature of Physician	**Date Signed**	**Date of last evaluation**

Please Note: knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

*Examples of acceptable sources for the Physician information include: licensed physicians or optometrists, and licensed or certified psychologists