PRESBYTERIAN

**Presbyterian Health Plan**
**Presbyterian Insurance Company, Inc.**

# Disabled Dependent Child Eligibility Questionnaire

If you have questions or need help completing this questionnaire, please call the Presbyterian Customer Service Center at (505) 923-5600 or toll-free at 1-888-275-7737. TTY users may call 1-877-298-7407. Please call Monday through Friday from 7:00 a.m. to 6:00 p.m.

**After completing this questionnaire, please mail to: Presbyterian Health Plan, Attn.: Enrollment Department, P.O. Box 27489, Albuquerque, NM 87125-7489**

## SECTION 1: Member Information

| Subscriber Name (Last, First, Middle Initial): | Date (MM/DD/YY): |
|---|---|
| Subscriber's ID Number: | Subscriber's Group Number: |

## SECTION 2: Disabled Dependent Child Information (To be completed by Subscriber)

| Full Name of dependent child: | | Date of Birth (MM/DD/YY): |
|---|---|---|
| Child's relationship to Subscriber : ☐ Parent ☐ Guardian ☐ Other: | Dependent Child's Gender: ☐ Male ☐ Female | Child's Marital Status: ☐ Married ☐ Single |

| | |
|---|---|
| 1. Does the dependent child rely on you for support? If "yes," what kind of support do you provide? | ☐ Yes ☐ No |
| 2. Is the dependent child claimed as a "Dependent" for tax purposes? | ☐ Yes ☐ No |
| 3. Does the dependent child live in your household? | ☐ Yes ☐ No |
| 4. Is the dependent child employed? If "yes", please complete below.<br>Employer Name: ☐ Full Time ☐ Part-Time<br>Type of Work (please describe): | ☐ Yes ☐ No |
| 5. How does the dependent child support him/herself? Please explain. | |
| 6. Does the dependent child receive or qualify for disability income? If "yes," please attach supporting documentation. | ☐ Yes ☐ No |

## SECTION 3: Physician's Report (To be completed by Primary Care Physician/Specialist)

| Primary Care/Specialist Name (Include Degree): | | Phone Number: | |
|---|---|---|---|
| Address: | City: | State: | ZIP: |

| | |
|---|---|
| 1. Diagnosis/Diagnoses: | |
| 2. Physical/behavioral limitations: | |
| 3. Current Treatment(s) and /or Medication(s): | |
| 4. Is this dependent child disabled or incapable of self-support? | ☐ Yes ☐ No |
| 5. Is this condition permanent or expected to improve? ☐ Permanent ☐ Improve | |

Primary Care/Specialist Signature _____ Date _____

## For Presbyterian Use Only

| Medical Director Decision: ☐ Approved ☐ Denied | Duration: |
|---|---|
| Medical Director Reviewer: | Date: |