



ND

4510 13th Avenue South  
Fargo, North Dakota 58121

APPLICATION FOR DEPENDENT DISABILITY

BENEFIT PLAN NUMBER \_\_\_\_\_  
Dependent's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Medicare ID Card Number \_\_\_\_\_  
Hospital Part A Effective Date [ ] [ ] 0 1 [ ] [ ]  
Medical Part B Effective Date [ ] [ ] 0 1 [ ] [ ]  
Prescription Drug Part D Effective Date [ ] [ ] 0 1 [ ] [ ]

SUBSCRIBER'S STATEMENT - to be completed by subscriber.

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, uses 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? \_\_\_\_\_ What grade level? \_\_\_\_\_  
Mainstream (in non special education class) experience: \_\_\_\_\_

9. Is dependent blind and/or deaf?  Yes-Blind  Yes-Deaf  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 (ADL'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. needs assist to wheelchair, 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 sufficient education, and training.  
Disability is of a nature that dependent status WILL change after sufficient education, and training.

**PHYSICIAN STATEMENT – to be completed by the attending physician.**

This is to certify that \_\_\_\_\_  
has the specific diagnosis(es) (ICD-9-CM)

- This dependent is receiving the following medications:

- The disability is of a permanent nature (ie. anencephalic, 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)

- The disability is of a partial nature (ie. blind, deaf, educable mental retardation, etc.)  
(Be specific)

- There is potential for independent living with appropriate education at sometime in the future.

I hereby authorize Doctor \_\_\_\_\_ to complete this form and forward it to the Blue Cross Blue Shield of North Dakota office at 4510 13<sup>th</sup> Avenue South, Fargo, North Dakota 58121.

Subscriber Signature: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_