



PHYSICIAN FORM FOR HANDICAPPED DEPENDENT
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58798 (Rev. 12-2009)

58798

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME	
NDPERS Member Id	Last Four Digits of Social Security Number		Date of Birth
SUBSCRIBER'S ADDRESS:			
Street:			
City:	State :		Zip Code:
NAME OF INSURANCE PLAN:		INSURANCE PLAN CODE:	ID NUMBER:
GROUP NAME		NDPERS Organization ID	

Please respond to the questions below in as complete a manner as possible. This information will assist the insurance provider in determining this patient's eligibility for continued insurance coverage as a handicapped dependent.

<i>To Identify the Treating Physician:</i>			
Physician Name:			
Specialty:			
License Number:			
Address:			
Telephone Number:		Fax Number:	
Diagnosis(es) (ICD-9):			
1. How long have you treated this patient and when did you last see him/her?			
2. What is the degree of physical/mental impairment?			
3. In your professional opinion, is this patient continuously incapable of self-sustaining employment due to a physical or mental handicap? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, please explain.			

SUBSCRIBER'S NAME (EMPLOYEE)	NDPERS Member Id
4. How long has this patient been incapable of self-sustaining employment? (Please answer this question based upon your understanding of the patient's medical history.)	
5. When, in your professional opinion, might this patient be capable of self-sustaining employment?	
6. Is the individual trainable/educable?	
Physician's Signature _____ Date _____	
Physician Printed Name: _____	

Please mail this form to: To your health care provider listed on the back of your ID card.