Proof of Incapacity of a Dependent

PHYSICIAN'S FORM

Subscriber Name _____ Subscriber # _____

Address _____

Dependent Name _____

The insurer covers dependent children that have reached the maximum dependent age and are physically or mentally incapacitated. In order to make a determination, the following information must be completed. ***Please attach any supporting documentation.***

Current Age _____ Height _____ Weight _____ Mental Incapacity ❑Yes ❑No If Yes, Add IQ Score _____

Physical Incapacity ❑Yes ❑No Age at Onset of Condition/Disability _____

Describe incapacity or reason incapable of self care/self support _____

_____

Describe acute medical conditions _____

_____

Describe chronic medical conditions _____

_____

Future health concerns or considerations _____

_____

Medications, dosage, reason for medications _____

_____

Other important facts _____

_____

A copy of any pertinent medical information may be attached.

I have examined the dependent named above, and the degree of his/her disability or incapacity is of such a nature that he/she is incapable of self care/self support.

_____ _____

Physician Name Specialty

_____ _____

Physician Signature Date

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Arkansas Blue Cross and Blue Shield
ATTN: Small Group Underwriting
P.O. Box 2181
Little Rock, AR 72203-9974
Fax 501- 378-2926
Email: smallgroupunderwriting@arkbluecross.com

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage
ATTN: Small Group Underwriting
P.O. Box 2181
Little Rock, AR 72203-9974
Fax 501-378-2926
Email: smallgroupunderwriting@arkbluecross.com