Disabled Dependent Certification

DELTA DENTAL

Delta Dental of Oregon & Alaska

Section 1: Your Information

Primary member/subscriber name	Subscriber ID number.
Dependent name	Group number

Section 2: Medical report (to be completed by attending physician)

Dates pertaining to this condition from	Dates pertaining to this condition to	Date of disability onset
Did the disability begin prior to the child reaching 26 years of age and exist ☐ Yes ☐ No		

If a subscriber has a child who has sustained a disability rendering him or her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over 26 years old. Mental incapacity means intellectual competence usually characterized by an IQ of less than 70, and physical incapacity means the inability to pursue an occupation or education because of a physical impairment. To be eligible, the child must be unmarried and principally dependent on the subscriber for support. The incapacity must have arisen before the child's 26th birthday and the child must have had continuous medical coverage.

ICD-9 Disease Code, Primary (required) or DSM IV Code(s), if any
Statement of symptoms and clinical findings (Physical or Psychological/Psychiatric)

Review the Functional Assessment of Activities of Daily Living (ADLs):

For the skills you are aware of indicate the patient's degree of physical and mental disability. Usinga scale of 1 to 10 indicate on the appropriate ADLs. One (1) indicates the ADL is not affected by the patient's disability. A ten (10) indicates the patient is completely disabled in the ADL skill or ability. These functional disabilities limit the Patient's capacity for self-support.

Mobility skills

_____ walking
_____ sitting
_____ standing
_____ lifting
_____ bending

Self-care skills

_____ feeding
_____ bathing
_____ toileting
_____ dressing

Sensory skills

_____ hearing
_____ seeing
_____ speech
_____ touch

Cognitive skills

_____ judgment
_____ memory
_____ planning/follow through
_____ thinking/proc

Based on your examination, please select the appropriate statement:

☐ The patient **DOES NOT** have a disability or the current disability **DOES NOT** render him or her incapable of self-support.

☐ The patient's current disability **DOES** render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self- support by (projected date) _____ . Please make some estimate, including month and year, of when the condition is likely to improve or resolve.

☐ The patient's current disability is of permanent or extended duration and, consequently, the patient is not and will not be capable of self-support within the foreseeable future (e.g., more than five years).

Section 3: Authorization (to be completed by attending physician)

I certify that, based on my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self-support, and that I am a (your specialty)			
Physician's name as shown on license	Original signature of attending physician X		
Physician's address	City	State	ZIP
Phone	Date (mm/dd/yyyy)		

Ready to submit? Mail this form to Delta Dental:
Attn: Billing and Eligibility
601 SW Second Ave., Portland, OR 97240-0168

Questions? Contact customer service at 855-294-1668. (TTY users, dial 711.)

DeltaDentalAK.com | **DeltaDentalOR.com**