AmeriHealth NEW JERSEY

Please Mail To:
AmeriHealth Insurance Company
P.O. BOX 41574
Philidelphia, PA 19101-1574

Handicap Child Claim Form (see reverse side for instructions)

MEMBER INFORMATION		
Member's Name (First, Middle, Last)	Identification No.	
Present Address-Street	City, State	Zip Code
Employer's Name (First, Middle, Last)		
Employer's Address-Street	City, State	Zip Code
I HEREBY APPLY FOR CONTINUATION OF COVERAGE FOR THE FOLLOWING CHILD UNDER MY SUBSCRIPTION AGREEMENT(S):		
Name of Dependent (First, Middle, Last)	Birthdate	
Realtionship to Member	Is Dependent Married? ☐ No ☐ Yes	

Is the dependent:
- a. Receiving benefits ☐ No ☐ Yes
- b. Covered by Medicare ☐ No ☐ Yes
- c. Receiving Social Security benefits ☐ No ☐ Yes

(If yes, please attach copy of "Notice of Award" or most recent notice of benefit changes)

Is dependent currently covered as a handicap/disabled dependent by another carrier? ☐ No ☐ Yes
(If yes provide carrier name and ID number):_____

Why are you applying for continuation of benefits for the dependent at this time?
_____

Can dependent perform Activities of Daily Living (i.e. bathing, dressing, eating)? ☐ No ☐ Yes

Can dependent travel to and from a destination unattended? ☐ No ☐ Yes

Does dependent work for wages? ☐ No ☐ Yes

What are the specific ways in which you support / assist the dependent:
_____
_____

If your dependent is presently enrolled under his/her own AmeriHealth Agreement, give:
- ID No.:_____
- Group Plan No.:_____
- Location:_____

I hereby certify that the above child is unmarried, is incapable of self-support, is dependent upon me for more than half of his or her support and that his or her disability commenced prior to age 19.

I understand and agree as follows: That the requested coverage for the above child shall not become effective unless and until this application is accepted and approved by AmeriHealth and thereafter may be revoked by AmeriHealth if any of the statements made herin are incorrect or if AmeriHealth later determines that the above dependent no longer qualifies for coverage as a handicapped dependent; that this application will become a part of my original application and will be subject to the terms of my subscription agreement(s); and; that acceptance of this application does not confer eligibility upon the above child for Major Medical benefits unless the group agreement describing the Major Medical program so stipulates.

I further understand and agree that AmeriHealth reserves the right to request additional documentation if required.

Signature:_____ Date: _____

Instructions

Note: Any fee for the completion of this form is the responsibility of the member.		
Physician's name:	Degree/Specialty:	
Present Address-Street	City, State	Zip Code
Phone Number:		

1. The noted patient is presently under my care ☐ No ☐ Yes

2. Date dependent was last treated: _____

3. Diagnosis and concurrent conditions resulting in disability: _____
   If mentally impaired, define mental impairment in terms of mental age _____, IQ _____, or functional capacity in work, educational, or social setting _____
   If physically impaired, define physical impairment in terms of capacity to perform activities normally performed by individuals of comparable age, intellectual capacity _____
   Is condition temporary or permanent _____ static or progressive _____

4. Has such disability existed continuously since before dependent attained age 19? ☐ No ☐ Yes

5. Has dependent been confined in a hospital as a result of this disability? ☐ No ☐ Yes
   If yes, give name and address of hospital: _____
   Date admitted: _____ Date released: _____

6. Current treatment:
   A. Medication – i.e. dosage, frequency _____
   B. Care plan _____
   C. Compliance with prescribed treatment ☐ Good ☐ Fair ☐ Poor
   D. Currently controlled with medical management? ☐ No ☐ Yes (If no, why not _____)
   E. Goals/Expected Outcome _____

7. Prognosis:
   Is dependent totally disabled? ☐ No ☐ Yes
   Is dependent capable of self-support? ☐ No ☐ Yes
   Do you expect a fundamental or marked change in the dependent's condition in the future? ☐ No ☐ Yes
   If yes, when will the patient recover sufficiently to be capable of self support? _____
   If no, please explain: _____

8. Additional remarks: _____

Signature: _____ Date: _____

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