Please send completed form to:
AHMembershipDisabilityApplication@amerihealth.com
or
AmeriHealth New Jersey
Enrollment Services Department
1901 Market Street, Philadelphia, PA 19103

APPLICATION TO CONTINUE COVERAGE FOR DISABLED DEPENDENT CHILD

Member Name: _____ Identification No.: _____

Street address: _____ City: _____ State: _____ Zip: _____

Employer's Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

I HEREBY APPLY FOR CONTINUATION OF COVERAGE FOR THE FOLLOWING CHILD UNDER MY SUBSCRIPTION AGREEMENT(S):

Name of dependent: _____ Date of Birth: _____

Relationship to member: _____ Is dependent married? Yes ☐ No ☐

Is the dependent:

a) Receiving Medical benefits? Yes ☐ No ☐

(If yes, please provide the required carrier name, ID number, and effective date): _____

b) Covered by Medicare? Yes ☐ Eff Date _____ No ☐

c) Receiving Social Security benefits? Yes ☐ No ☐

(If yes, please provide the required documentation: effective date, copy of 'Notice of Award', and most recent notice of benefit changes) Eff Date _____

Is dependent currently covered as a disabled dependent by another carrier? Yes ☐ No ☐

(If yes, please provide the required documentation: carrier name, ID number, effective and cancellation dates, and proof of disability under another carrier) _____

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)? Yes ☐ No ☐

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

Does dependent work for wages? Yes ☐ No ☐

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

_____

If your dependent is presently enrolled under his/her own AmeriHealth New Jersey 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 26.

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 herein are incorrect or if AmeriHealth later determines that the above dependent no longer qualifies for coverage as a disabled 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.

Policy Holder Signature: _____ **Date**: _____

APPLICATION TO CONTINUE COVERAGE FOR DISABLED DEPENDENT CHILD

Certification of Attending Physician (must be completed by attending/treating physician)

Note: Any fee for the completion of this form is the responsibility of the member.

Physician's name: _____ Degree/Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

1. Patient Name_____ **DOB** _____

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

3. Date dependent was last treated: _____

4. Diagnosis and concurrent conditions resulting in disability: _____

_____

If mentally impaired, it is **required** to define mental impairment in terms of Mental Age _____ and/or IQ ____ .

In addition to mental age and/or IQ please define 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: _____

5. Has such disability existed continuously since before dependent attained age 26? Yes ☐ No ☐

6. Has dependent been confined in a hospital as a result of this disability? Yes ☐ No ☐

If yes, give name and address of hospital:_____

Date admitted:_____ Date released: _____

7. 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? Yes ☐ No ☐ (if no, why not:) _____

_____

E. Goals/Expected Outcome _____

8. Prognosis:

Is dependent totally disabled? Yes ☐ No ☐

Is dependent capable of self-support? Yes ☐ No ☐

Do you expect a fundamental or marked change in the dependent's condition in the future? Yes ☐ No ☐

If yes, when will the patient recover sufficiently to be capable of self support? _____

_____

If no, please explain: _____

9. Additional remarks: _____

_____

Physician Signature: _____ **Date**: _____

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می‌باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ: اگر آپ اردو زبان بولتے ہیں تو آپ کے لئے مفت زبان مدد کی خدمات دستیاب ہیں۔ 1-800-275-2583 پر کال کریں۔

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.