Disabled Dependent Child Certification

FAX: 844-236-0933
E-mail: Disabled_dep_@uhc.com

Completing the Disabled Dependent Child Certification

Completion of this certification is required to apply for the Disabled Depended Child Benefit. This applies to dependents that are coming upon the limiting age and need benefits to continue due to a physical or mental disability **OR** for an over-age disabled dependent child when a Subscriber is a new enrollee with UHC and the dependent has not had a lapse in dependent group coverage under a subscriber. To determine if your dependent qualifies for the Disabled Dependent Child Benefit, completion of this form by the employee **AND** your dependent's treating medical provider is **required**.

Instructions

1. **Employee Statement Pages:** Sections I, II, III, and IV to be completed in their entirety by the employee. **Employee** is required to sign, date, and provide printed name in Section IV. Employee Confirmation, Signature and Date.

2. Employee to provide an Active copy of the "order/s" (*guardianship, conservatorship, court order, divorce decree)* employee has in place for the dependent if circled in Section II, Dependent Information and/or a Current (within the last 3 months) copy of the SSDI/SSI Benefit Statement if "Yes" was circled in Section III, Question 5.

3. Employee to provide a copy of the Proof of Prior Dependent "Group" Coverage documents, IF, 'YES' was circled in Section III, Questions 1 and/or 2. These documents MUST show both the subscriber's and dependent's information and MUST include the effective and cease dates, up to when you are requesting enrollment for your dependent with UHC, to include the type of benefit(s) (medical, dental, and/or vision) the dependent was enrolled in under a subscriber. (Please note individual group or exchange coverage, Medicare or Medicaid, as well as most Cobra coverages do not qualify as "Group" coverage/s)

4. **Medical Provider Statement Page:** To be completed in its entirety by the treating medical provider to include signature and date. **Please note**, the certification form MUST be received by this dept. within 3 months of the Medical Provider's dated signature.

5. Confirm all pages of the certification form have been completed in their entirety **AND** make a copy for your files before returning the form. *(omission of any information required will cause a delay or inability to process your request)*

6. Return all pages of the fully completed certification form and any additional documents to UnitedHealthcare at the email address or fax number shown below. Please submit only "ONE" fully completed certification form by "ONE" route. Submitting more than one certification form, unless otherwise instructed to, may cause a delay in the review of your request.

   Dependent Disability Dept.
   Email: disabled_dep_@uhc.com
   or
   Fax: 844-236-0933

Upon completion of the review process, you and/or your employer group will receive a letter advising of the review determination and coverage dates if applicable. Please allow up to 30 business days for review completion which begins from the date of receipt of all documents required.

For any additional questions regarding your dependent child's eligibility benefits, please contact your employer's Human Resources Department for further assistance.

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Reset Form

Employee's Statement

Employee to complete Sections I, II, III & IV. Omitted information will cause delays.

Section I. Employee Information

Group Number:	Employer Group Name:

What benefit coverages is this review request for? (select all applicable) ☐ **Medical** ☐ **Dental** ☐ **Vision**

PRINT Employee Name: (First, Middle, Last)

Employee Marital Status: --Select One--

Employee Date of Birth	Member/Subscriber ID#	Relationship to Dependent	Phone: (Including Area Code)

Employee Current Address(es) (Street, City, State, Zip Code)

Physical:

Mailing:

Email:

Section II. Dependent Information

Refer to your Member Handbook for who qualifies as an eligible dependent.

Select **all applicable** orders in place by Employee regarding Dependent. If selected, **submit an Active/Current copy** of each with this form.

☐ **Guardianship** ☐ **Court Order** ☐ **Conservatorship** ☐ **Divorce Decree**

PRINT Dependent Name: (First, Middle, Last)	Dependent Date of Birth

Dependent Marital Status: --Select One--

Does the Dependent physically reside with you on a daily basis at the same address?	--Select One--

If **NO**, provide reason for different residing address than employee below. (Example: Lives in a group home, medical facility, etc.)

Dependent Currently Resides at: (Street, City, State, Zip Code)

Physical:

Mailing:

Section III. Financial and Dependent Employment Information

1. Are you a New Employee with a New Employer and/or have new coverage with UHC?	--Select One--
1a. Was dependent covered under your prior or current Employer's Insurance Plan up to when enrolling with UHC?	--Select One--

1b. If **YES**, provide type/s of Coverage and dates.	Medical:	--Select One--	From:	To:
	Dental:	--Select One--	From:	To:
	Vision:	--Select One--	From:	To:

2. Is dependent over the age of 26 years old?	--Select One--

2a. If YES, provide a Proof of Prior Group Coverage Document from the prior employer group carrier showing the effective & cease dates AND the benefit types covered for the dependent and subscriber AND then proceeed to completing 2b, 2c, and 2d below.

2b. Prior Subscriber's Name:	Prior Insurance Carrier Name:

2c. Prior Employer Group Name:

2d. Prior Coverage type/s and dates:	Medical:	--Select One--	From:	To:
	Dental:	--Select One--	From:	To:
	Vision:	--Select One--	From:	To:

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Section III. Financial and Dependent Employment Information (Continued)

3. Complete 3a-3d to determine if you provide the majority of financial support & maintenance for the dependent…	
3a. Do you pay for the dependent's portion of the housing where he/she resides?	--Select One--
3b. Do you pay for the dependent's monthly food expenses?	--Select One--
3c. Do you pay for the dependent's monthly prescriptions (out of pocket)?	--Select One--
3d. Do you pay for the dependent's portion of the utilities (heat, light, water)?	--Select One--
Please note, supporting documentation to the answers provided above in question 3 may be requested	
4. Federal Personal Income Tax Return - What was the Last Tax Year you Claimed the dependent?	
5. Does dependent receive SSDI/SSI benefit?	--Select One--
5a. If YES, Amount per Month.	**$**
5b. If YES, submit a copy of current SSDI/SSI Benefit Statement.	--Select One--
6. Is dependent currently working?	--Select One--
6a. If dependent is NOT currently working, Date Last Employed.	
6b. If dependent is currently working, Gross Monthly Income (before taxes).	**$**
6c. Is dependent's current position with employer eligible for health insurance?	--Select One--
6d. If answered YES, above in **6c**, Is dependent carrying "own" health insurance?	--Select One--
6e. If answered NO, above in **6d**, provide explanation as to why dependent is not carrying "own" coverage.	
6f. Provide Name and address of dependent's current employer below: (Street, City, State, Zip Code)	
7. Is dependent currently a student in post-secondary schooling?	--Select One--
7a. If yes, enrolled:	--Select One--
7b. Grade/Level:	
7c. School type:	
7d. If No, When was the last date attended?	
7e. If No, What was the highest degree or grade level of schooling completed?	
8. Does dependent hold a valid driver's license?	--Select One--
9. Provide any further Explanations/Additional Information: (attach additional pages if needed)	

Section IV. Employee Confirmation, Signature and Date

I confirm I have completed the Employee's Statement in it's entirety. I know it is a crime to fill out this form with information I know is false or leave out information I know is important.

PRINT Employee Name: _____

Employee Signature: _____ **Date:** _____

For processing purposes, Employee's Statement and Medical Provider Statement MUST be submitted together.

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THIS PAGE IS TO BE COMPLETED IN FULL BY THE DEPENDENT'S TREATING MEDICAL PROVIDER ONLY.

Medical Provider Statement

(Any fee for the completion of this statement is to be paid by the employee.)
Answer all questions below. Omitted information will cause delays.

Patient 's Name: (First, Middle, Last)	**Patient's Date of Birth**

1. What is the primary disabling diagnosis?

2. Age diagnosed with Primary Disabling Diagnosis? --Select One--	Years of Age:

3. The patient is presently: (Select all applicable) ☐ Ambulatory Confined To: ☐ Bed ☐ House ☐ Hospital ☐ Wheelchair

4. What are the physical/mental/functional limitations related to the primary disabling diagnosis?

5. Are there any other diagnoses currently being treated?	--Select One--

5a. If YES, please list:

6. Is patient currently able to work? --Select One--	**6a. If YES, the patient is able to work**	--Select One--
7. Is patient currently able to be "financially" self-supportive (does not need financial help from others)?		--Select One--
8. Is patient currently physically able to care for self in all aspects of ADLs (activities of daily living)?		--Select One--

9. If answered NO in 7 & 8 above. Please explain below.

☐ **Intellectual/Developmental Disability** ☐ **Physical Handicap** ☐ **Mental Handicap** ☐ **Other** (Explain below)

10. Will patient be capable of self-support in the future?	--Select One--
10a. If yes, as of what date?	

☐ **Check box if documents Attached. Current written documentation or medical records (within the last three (3) months).**

I confirm I have completed the Medical Provider Statement in it's entirety. I know it is a crime to fill out this form with information I know is false or to leave out information I know is important.

Medical Provider Signature: _____ **Date:** _____

PRINT Medical Provider Name, Address (Street, City, State, Zip Code)	Phone: (Including Area Code)

For processing purposes, Employee's Statement and Medical Provider Statement MUST be submitted together.