Disabled Adult Dependent Evaluation

To verify your dependent's eligibility as a disabled adult dependent with Avera Health Plans, please complete and return the Disabled Adult Dependent Evaluation Forms A and B within 10 business days:

- **Form A** – must be completed by you, the subscriber.
- **Form B** – must be completed by your dependent's treating physician.

Both forms are required and need to be mailed to:

Avera Health Plans
Attn: Enrollment
5300 S Broadband Ln
Sioux Falls, SD 57108-2221

Fax to: 605-322-4689

Email to: ahpenrollment@avera.org

Any medical records provided will only be used to determine disabled adult dependent eligibility and will be kept confidential. All costs associated with the reproduction of medical records are the responsibility of you, the subscriber.

If you have any questions, our Customer Care Team is available Monday through Friday at 605-322-4245 or toll-free at 888-322-2115.

Avera Health Plans

Disabled Adult Dependent Evaluation

FORM A – Subscriber Information: This form must be completed by the subscriber.

1. Subscriber's Name: _____ 2. Subscriber's Number: _____
3. Address: _____

   City: _____ State: _____ ZIP Code: _____
4. Dependent's Name: _____ 5. Birth Date: _____
6. Dependent's Relationship to Subscriber: _____
7. Dependent's Address(If different than Subscriber's Address): _____

   City: _____ State: _____ ZIP Code: _____
8. Name of Provider/Physician Treating Condition: _____

   List Condition(s): _____
9. How long has this disability existed? ☐ Since birth

   ☐ Other (indicate month/year of onset): _____

   Most recent treatment of the condition (month/year): _____
10. Attends School: ☐ No ☐ Yes, full-time ☐ Yes, part-time (hours per week): _____

    Name of school: _____
11. Able to Work: ☐ No ☐ Yes, Company Name: _____ Hours per week: _____

    If no, how does the condition prevent him OR her from working? _____

    Date Last Worked: _____

    Company Name Where Last Worked: _____

    Description of Work: _____

    ➢ **Please attach copy of most recent W2 or 1099 form.**
12. ☐ Yes ☐ No The dependent has been found by the Social Security Administration to be "disabled" and eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). If yes, please attach Notice of Award letter.
13. ☐ Yes ☐ No The dependent listed above is the unmarried natural child, stepchild or adoptive child of my spouse or myself and is over the age of 25.
14. ☐ Yes ☐ No The dependent listed above resides with me or my spouse. If no, please explain:

    _____
15. ☐ Yes ☐ No The dependent has been claimed as a dependent for income tax purposes by me or my spouse.
16. ☐ Yes ☐ No The dependent has had other health insurance coverage immediately prior to the request of the new effective date. If yes, please attach a Certificate of Creditable coverage or supply the following information:

    Name of Insurance Carrier: _____

    Date Previous Insurance Began: _____ Date Coverage Ended: _____

I authorize the release of medical information to Avera Health Plans and its medical directors for review and I attest to the accuracy of the information contained within this form. I understand that my dependent's enrollment is subject to Avera Health Plans' approval and periodic review.

Signature of Subscriber: _____ Date: _____

NOTE: References to Avera Health Plans signify Avera Health Plans, Inc. or Avera Health Plans Benefit Administrators, as applicable.

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Form B – Physician Information: This form must be completed by the treating provider.

(For additional information, add pages or use the back of this sheet.)

1. Patient's name: _____
2. Patient's date of birth: _____
3. Patient's Avera Health Plans Member ID Number: _____
4. Diagnosis: _____
5. Date of Onset of the Disability: _____
6. List specific physical and/or mental restrictions: _____
7. Degree of Physical Disability: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
   No Disability to Moderate Disability to Severe Disability
8. Degree of Mental Disability: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
   No Disability to Moderate Disability to Severe Disability
9. Resulting Hospital Confinements and Dates: _____
10. Current Plan of Treatment: _____
11. Medications: _____

_____

12. ☐ Yes ☐ No In your professional opinion, does the disability prevent the patient from engaging in any substantial, gainful activity?

    Comments: _____
13. ☐ Yes ☐ No In your professional opinion, could the disability improve?

    If yes, how long could the disability be expected to prevent the patient from engaging in any substantial, gainful activity?

    ☐ Less than 6 months ☐ 6 to 12 months ☐ 12 to 18 months ☐ Other _____

Remarks: _____

_____

_____

Please attach all relevant medical documentation that supports the disability diagnosis, including office notes, specialist consultations, progress reports and treatment plans.

_____ _____

Physician's Signature Printed Name of Physician

Office Location: _____ Phone: _____

Please Mail Form B to:

Mail to Avera Health Plans, Attn: Enrollment, 5300 S Broadband Ln, Sioux Falls, SD 57108-2221 or fax to 605-322-4689. You may send it electronically by email to ahpenrollment@avera.org.
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