

TO BE COMPLETED BY DEPENDENT'S ATTENDING PHYSICIAN (M.D. or D.O.)

1. Diagnosis (Please use standard nomenclature): _____

2. If physically disabled, describe physical impairments: _____

3. If mental illness*, describe limitations: _____

4. If 2 or 3, describe treatment and rehabilitation currently being administered to dependent: _____

5. If mental retardation*, describe severity of condition: _____
Mental Age: _____ I.Q.: _____

Describe capabilities and limitations of dependent: _____

***PLEASE ATTACH A COPY OF DEPENDENTS LAST PSYCHOLOGICAL EVALUATION, WAIS AND/OR MMPI REPORT.
YOU MUST COMPLETE THIS AREA IN FULL FOR THE DEPENDENT:**

✓CHECK ALL THAT APPLY:

| Yes | No | Yes | No | Yes | No | Yes | No |
|--------------------------|--------------------------|---------------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feed Self | Dress Self | Bathe Self | Toilet Self | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Read | Write | Speak | Handle Money | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drive Vehicle | Ambulate Independently | Transfer Self From Bed to Chair | Use Public Transportation | | | | |

6. To your knowledge, length of time this disability has existed: _____

7. Probable future course and duration: _____

8. Is dependent institutionalized? Yes No If yes, give name of institution _____

9. In your professional opinion, can this patient engage in self-supporting employment? Yes No
Please elaborate the reason for your answer: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Physician Signature _____ Date _____

Name of Physician (please print) _____ Phone Number: _____

Physician's Address _____

Office Use Only

Not Approved - Reason: _____
 Approved Effective date _____ Processed by _____ Date _____

If you have any questions, please contact your Group Administrator/Representative.
Or, visit us at: www.excellusbcbs.com