Continuation of health plan coverage for incapacitated dependent request form

You can request continued health plan coverage for a dependent who is considered incapacitated due to a mental or physical disability, even after they reach the age limit for dependent coverage, which is 26 years of age.

What must be done to submit a request?

When submitting a request, you **must** take the following action:

- Complete, sign and submit this form.
- Attach documentation relating to your request. This includes:
  - Supplemental Security Income (SSI) benefits, submitted or approved Social Security Disability Insurance (SSDI) paperwork, Americans with Disability Act (ADA) paperwork, employment records, etc. ***Always send copies. Never send original documents.***

Omitted information and documents may cause delays and lapse in coverage.

Where do I send the completed form?

Return the completed form to Priority Health by:

Mail
Priority Health
Attn: Enrollment Department
1231 East Beltline NE
Grand Rapids, MI 49525

Email
ph-enrollment@priorityhealth.com

What if I have questions?

Contact our Customer Care team by calling the number on the back of your member ID card or log in to your member portal account at ***member.priorityhealth.com*** to send us a message.

1. Priority Health plan policyholder information			
Legal first name	Legal last name		M.I.
Date of birth _____/_____/_____	Priority Health contract number		
Group number	Group name		
Street address			Unit/apt./lot no.
City	State		Zip Code
Email			Phone ( ) -

2. Dependent information

Legal first name	Legal last name	M.I.
Date of birth _____/_____/_____	Relationship to policyholder	

Marital status

☐ Single ☐ Married

If 'Married', what is the marriage date? _____/_____/_____

Is the future member considered a dependent?

☐ Yes ☐ No

Incapacity is defined as an inability to perform basic self-care and/or an inability to function independently, e.g., unable to work, attend school or socialize without assistance. Using this definition, do you believe the dependent is incapacitated?

☐ Yes ☐ No

If 'Yes', what age did the dependent become incapacitated? _____

The American Disabilities Act (ADA) defines a person with a disability as someone who has a physical or mental impairment that substantially limits one or more major life activity. Using this definition, do you believe the dependent is disabled?

☐ Yes ☐ No

Does the policyholder provide more than 50% of the total support of the dependent?

☐ Yes ☐ No

Does the dependent receive Supplemental Security Income (SSI) benefits?

☐ Yes *(please include any documentation and medical records stating qualification)* ☐ No

If 'Yes', what is the amount per month? $_____

Does the dependent receive Social Security Disability Insurance (SSDI) benefits?

☐ Yes *(please include any documentation and medical records stating qualification)* ☐ No

If 'Yes', what is the amount per month? $_____

What is the estimated income the dependent receives monthly from all sources?

$_____

Was the dependent listed on your last Federal Income Tax Return as a dependent?

☐ Yes ☐ No

If 'No', explain:

Is the dependent able to socialize without support?

☐ Yes ☐ No

If 'No', explain:

Does the dependent live with the policyholder?

☐ Yes ☐ No *(complete section 2a.)*

Does the dependent reside in adult foster care?

☐ Yes ☐ No

If 'No', has foster care for the dependent been sought? ☐ Yes ☐ No

2a. Current dependent address

Street address		Unit/apt./lot no.
City	State	Zip Code
Email		Phone ( ) -

Describe the reason why the dependent does not live with the policyholder:

3. Guardian information *(please attach documentation)*

Legal first name	Legal last name	M.I.

What is the type of guardianship?

☐ Permanent ☐ Temporary

4. Employment information

Is the dependent currently employed?

☐ Yes *(complete section 4a.)* ☐ No

If 'No', was the dependent ever employed? ☐ Yes ☐ No

If 'Yes', when was the dependent last employed? _____/_____/_____

Is the dependent currently attending school?

☐ Yes (complete section 3c.) ☐ No

4a. Employment details

What type of employee is the dependent? ☐ Full-time ☐ Part-time	Employer name	
Street address		Unit/apt./lot no.
City	State	Zip Code

5. School information

Is the dependent currently attending school?

☐ Yes *(complete section 5a.)* ☐ No

If 'No', did the dependent ever attend school? ☐ Yes ☐ No

If 'Yes', when did the dependent last attend school? ____/____/____

5a. School details

What type of student is the dependent? ☐ Full-time ☐ Part-time	School name	
Street address		Unit/apt./lot no.
City	State	Zip Code

6. Acknowledgement

Priority Health plan policyholder signature	Today's date ____/____/____

THE FOLLOWING SECTIONS TO BE COMPLETED BY ATTENDING PHYSICIAN

7. Physician information

First name	Last name	M.I.
Street address		Unit/apt./lot no.
City	State	Zip Code
Email		Phone ( ) -

8. Patient information

First name	Last name	M.I.
Date of birth ____/____/____	Onset date of disability ____/____/____	Onset age of disability

Patient status *(mark all that apply)*

☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined ☐ Wheelchair confined

Is the patient capable of performing the following activities? *(mark all that apply)*

☐ Bathing ☐ Cooking ☐ Dressing ☐ Eating ☐ Manage money ☐ Toileting ☐ Using a phone

Has a Durable Power of Attorney for Health Care been completed?

☐ Yes *(please attach documentation)* ☐ No

If yes, what is the patient agent identifier? _____

Have the advanced directives been completed and on file in your office?

☐ Yes (please attach documentation) ☐ No

9. Diagnosis information

Diagnosis name	ICD-10-PS code

Date of first exam	Date of most recent exam
____/____/____	____/____/____

Clinical description to support incapacity:

Does the patient have any physical and/or functional limitations?

☐ Yes ☐ No

If 'Yes', explain:

Does the patient have a cognitive/development disability?

☐ Yes ☐ No

If 'Yes', explain:

Is the patient mentally ill?

☐ Yes ☐ No

If 'Yes', explain:

Is the patient intellectually impaired?

☐ Yes ☐ No

If 'Yes', explain:

Has the patient completed standardized intellectual and developmental testing?

☐ Yes ☐ No

If 'Yes', what date was the testing completed? _____/_____/_____

If 'Yes', what is the patient's IQ?

☐ Functional (IQ 85 and above) ☐ Borderline (IQ 71-84) ☐ Mild (IQ 50-70)

☐ Moderate (IQ 35-49) ☐ Severe (IQ 34 and below)

Has the patient received any treatment, including surgery or therapy?

☐ Yes ☐ No

If 'Yes', explain:

Is the patient taking any current medications?

☐ Yes ☐ No

If 'Yes', explain:

Describe the patient's prognosis:

Will the patient be capable of self-support in the future?

☐ Yes ☐ No

If 'Yes', what is the date the patient will be self-supporting? _____/_____/_____

10. Acknowledgement

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.

Physician signature	Today's date _____/_____/_____

**The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employer and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*