



**RETURN COMPLETED FORM TO:**

North Carolina State Health Plan  
 PO Box 30111 • Durham, NC 27702-3111

- Coverage Request for a Mentally or Physically Incapacitated Child**  
 **Recertification Request**

**SECTION A – TO BE COMPLETED BY MEMBER**

<b>1</b>	NAME OF MEMBER	ADDRESS OF MEMBER		MEMBER ID NUMBER
<b>2</b>	NAME OF DEPENDENT	SOCIAL SECURITY NUMBER OF DEPENDENT	DEPENDENT'S DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED
<b>3</b>	WAS DEPENDENT EVER INSTITUTIONALIZED? <input type="checkbox"/> YES → IF YES, GIVE NAME AND ADDRESS OF INSTITUTION(S).....AND → <input type="checkbox"/> NO			PERIOD CONFINED FROM: TO:
<b>4</b>	IS DEPENDENT ELIGIBLE FOR CARE UNDER FEDERAL, STATE OR LOCAL LAW? <input type="checkbox"/> YES → IF YES, GIVE DETAILS: <input type="checkbox"/> NO			
<b>5</b>	IS DEPENDENT ELIGIBLE FOR MEDICARE? <input type="checkbox"/> YES → IF YES, GIVE EFFECTIVE DATES: <input type="checkbox"/> NO	PART A	PART B	
<b>6</b>	WAS, OR IS, DEPENDENT EMPLOYED FOR WAGES? <input type="checkbox"/> YES → IF YES, GIVE NAME AND ADDRESS OF CURRENT OR LAST EMPLOYER: <input type="checkbox"/> NO			AVERAGE WEEKLY EARNINGS: \$
<b>7</b>	IF DEPENDENT WAS EMPLOYED, GIVE REASON FOR TERMINATION:			
<b>8</b>	IS DEPENDENT CHILD CURRENTLY COVERED UNDER YOUR PRESENT COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS DEPENDENT CHILD CURRENTLY COVERED UNDER A SEPARATE CONTRACT? <input type="checkbox"/> YES → IF YES, GIVE MEMBER ID NUMBER <input type="checkbox"/> NO		
<b>9</b>	IS DEPENDENT CHILD CURRENTLY CLAIMED FOR INCOME TAX EXEMPTION UNDER THE U.S. INTERNAL REVENUE CODE? <input type="checkbox"/> YES <input type="checkbox"/> NO	SIGNATURE OF MEMBER:		DATE SIGNED:
<b>10</b>	WAS THE DATE OF INCAPACITATION PRIOR TO AGE 19? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>11</b>	WAS THE DATE OF INCAPACITATION BETWEEN 19 AND 26? <input type="checkbox"/> YES <input type="checkbox"/> NO	AND	WAS CHILD COVERED BY THE PLAN AS A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**SECTION B – TO BE COMPLETED BY CERTIFYING PHYSICIAN**

IS DEPENDENT PRESENTLY INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF: <input type="checkbox"/> MENTAL INCAPACITATION <input type="checkbox"/> PHYSICAL HANDICAP	IS INCAPACITY CONGENITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF INCAPACITATION OR DATE OF ONSET OF INCAPACITATION:
DIAGNOSIS OF CONDITIONS CAUSING INCAPACITATED STATUS:		
WILL THIS DEPENDENT BE INCAPABLE OF SELF-SUSTAINING EMPLOYMENT FOR AN EXTENDED PERIOD OF ONE YEAR OR LONGER? <input type="checkbox"/> YES → IF YES, HOW LONG?.....AND → <input type="checkbox"/> NO	IS DEPENDENT PERMANENTLY INCAPACITATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>PLEASE PROVIDE DETAILS EXPLAINING THE DEGREE OF INCAPACITATION AND/OR FUNCTIONAL LEVEL, TREATMENT AND PROGNOSIS:</b>		
IF ADMITTED AS INPATIENT, GIVE NAME OF HOSPITAL:		DATE ADMITTED:
NAME OF CERTIFYING PHYSICIAN:	ADDRESS:	
SIGNATURE OF CERTIFYING PHYSICIAN:		DATE SIGNED:

**SECTION C – FOR INTERNAL OFFICE USE ONLY**

	BY	DATE	REMARKS:
REC'D			
APP'D			
EFFEC			