



Dear Subscriber,

In order to verify your dependent's eligibility as a disabled adult dependent, please return the following information to Harvard Pilgrim Health Care (HPHC):

1. A completed "Subscriber Section – HPHC Disabled Adult Dependent Evaluation" form.
2. All relevant medical records related to the dependent's disability.

Note: The enclosed "Member Authorization to Obtain Protected Health Information" form should be signed by the applying dependent and forwarded to the treating physician for the purpose of obtaining medical records.

3. A completed "Physician Section – HPHC Disabled Adult Dependent Evaluation" form.

All of the above materials are required and must be returned to:

**Harvard Pilgrim Health Care
Disability Verification – Account Services
1600 Crown Colony Drive
Quincy, MA 02169**

In Connecticut, the above materials must be provided within 31 days of the disabled adult dependent's loss of eligibility after turning age 26.

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

If you have any questions, please call the Member Services Department at 1-888-333-4742, weekdays between 8:00 a.m. and 5:30 p.m. If you are deaf or hard-of-hearing, please call 1-800-637-8257 for TTY service.

Sincerely,

Member Services Department



1. Subscriber name: _____

2. Subscriber's HPHC ID # or Social Security #: _____

3. Home address: _____

City: _____ State: _____ Zip Code: _____

4. Dependent's Name: _____ Birth Date (MM/DD/YYYY): _____

5. Dependent's Social Security #: _____

6. Dependent's Relationship to Subscriber: _____

7. Dependent's Address: _____

City: _____ State: _____ Zip Code: _____

8. Dependent's Medical Condition(s): _____

9. How long has this disability existed? [] Since Birth [] Other (indicate Month/Year of outset): _____

10. Most recent treatment of the condition (Month, Year): _____

11. Attend School: [] Yes, full-time [] Yes, part-time (Hours per week): _____ [] No

Name of School: _____

12. Able to work: [] No [] Yes, company name: _____ Hours per week: _____

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

When last worked: _____

Company last worked: _____

Description of work: _____

**Please attach copy of most recent W2 or 1099 form*

13. [] Yes [] No Has the dependent been found eligible as "disabled" by Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)? (If Yes, please attach Notice of Award Letter)

14. [] Yes [] No Is the dependent currently enrolled or has the dependent ever been enrolled in Medicare Part A or Part B? (If yes, please provide the Medicare Claim Number): _____

15. [] 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 19.

16. [] Yes [] No The dependent listed above resides with me or my spouse. If No, please explain: _____

17. [] Yes [] No Had other health insurance coverage immediately prior to the request of the new effective date. (Please attach a certificate of credible coverage or supply the following information):

Name of insurance carrier: _____

Date previous insurance ended: _____

I authorize the release of medical information to HPHC 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 HPHC approval and periodic review.

Signature of Subscriber: _____ Date: _____



Member Authorization to Obtain Protected Health Information

Section 1: Member Information

Member's Name _____ Home Telephone: _____
HPHC ID # or Social Security #: _____ Birth Date (MM/DD/YYYY): _____
Home Address: _____
City: _____ State: _____ Zip Code: _____

Section 2: Information Being Requested

I hereby authorize HPHC to obtain the following information, noted below (Be specific and include doctors/ providers names, type of information and dates.): For example: HPHC may obtain records for my heart condition prior to my enrollment in the Plan from MGH from 1995 - 1998.

This information may be used for the following purpose(s):

For example: To consider my application and determine if HPHC will approve my request for enrollment. (It is sufficient for a member to indicate 'at my request' if he/she elects not to detail the purpose).

Statutorily Protected Information

Please include the following type(s) of information. Such information cannot be released from your records unless you indicate your authorization by initialing the space next to each category and provide your signature below.

_____ Mental Health _____ Alcohol and Substance Abuse _____ Abortion _____ HIV Testing
_____ Physical Abuse _____ Sexually Transmitted Diseases _____ AIDS/ARC _____ Genetic Testing

I hereby authorize release of any data in my records for the categories indicated above by my initials.

Signature (Required)

Section 3: Terms of this Authorization

Please indicate that you have read and understand the terms of this Authorization.

If you need assistance or have questions, please call 1-888-888-4742 or TTY 1-800-637-8257.

- I understand that HPHC will not condition my treatment, enrollment or eligibility for health insurance benefits on my signing of this Authorization
- I understand that I may revoke this Authorization in writing at any time
- I understand this Member Authorization will remain in effect until the date of _____, or until I revoke it in writing, but no longer than 30 months from the date that I sign this authorization
- I understand that HPHC will not use or re-disclose the PHI obtained for any reason not indicated on this form
- I understand I have a right to receive a copy of this Authorization upon request

I have read and understand the terms of this Authorization and I hereby authorize the use and release of my health information in the manner described in this Authorization

Signature of Individual

Date

Printed name of Individual

****Note: If this form is signed by anyone other than you, the Member Authorization is not valid unless your Designated Personal Representative documentation is on file with HPHC.**

Signature of Designated Personal Representative (DPR)

Date

Printed name of DPR

If individual is a minor, please complete the information below:

Signature of authorized Legal Guardian

Date

Printed name of Legal Guardian

Relationship



Physician Section - HPHC Disabled Adult Dependent Evaluation

(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 HPHC ID# or Social Security: _____

4. Diagnosis: _____

5. Date of onset of the disability: _____

6. List specific physical and/or mental restrictions:

7. Degree of physical disability: None Mild Moderate Severe Profound

8. Degree of mental disability: None Mild Moderate Severe Profound

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?

13a. 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, treatment plans.

Physician's Signature _____

Printed Name of Physician _____

Location and Phone Number: _____

Please return questionnaire and medical records to:

Harvard Pilgrim Health Care
Disability Verification – Account Services
1600 Crown Colony Drive
Quincy, MA 02169