Dependent Disability Certification

Please complete certification form and mail to:

Valley Health Plan
Attn: Member Services Department
2480 N. First Street, Suite 200, San Jose, CA 95131
Fax: 408.885.4425

A dependent child who is incapable of self-support due to a continuously disabling illness or injury may be continued as a family member on the parent's Valley Health Plan contract. Physically or mentally handicapped Eligible Dependent(s) who is incapable of sustaining employment and is dependent upon you for support and maintenance may continue Coverage if the child was handicapped on the day before reaching age 26. The child can be covered under the Plan through age 25 or until the child recovers from the handicap or the date the child is no longer chiefly dependent on you for support and maintenance.

Parent/Subscriber's Information:

Last Name ______________________ First Name ______________________

Insurance ID # ______________________ Gender ☐ Male ☐ Female DOB ____________

Street Address ____

City/State/Zip ______________________ Phone # ______________________

Disabled Dependent's Information:

Last Name ______________________ First Name ______________________

Social Security # ______________________ Gender ☐ Male ☐ Female DOB ____________

Marital Status ☐ Married ☐ Single Relationship to Subscriber ______________________

Type of disability ____

Does subscriber claim the dependent for income tax purposes? ☐ Yes ☐ No

If "No", please explain ____

____

Does the dependent live with the subscriber? ☐ Yes ☐ No

If "No", please explain ____

____

Does the dependent currently have other health insurance coverage? ☐ Yes ☐ No

****If "Yes", please provide information related to other health insurance****

Insurance Company Name ____

Insurance ID # ______________________ Effective Date ____________

Policy Holder's Full Name ______________________ DOB ____________

Dependent's relationship to Policy Holder ______________________

I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.

Subscriber's Signature ______________________ Date ____________

Dependent Disability Certification

Physician's Certification

This section must be completed and signed by attending physician. The physician's medical statement will help the plan determine eligibility and continuation of benefits.

Patient's Full Name ____ DOB: ________________

Diagnosis ____

ICD-10 code(s) _________________; _________________; _________________; _________________

Please provide specifics as to the nature of the disability. (Attach supporting documentation)

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____

Please explain how the disability causes the patient to be incapable of working or living independently.

____

____

To what extent does the disability limit normal activity? (Attach supporting documentation)

____

____

What is your prognosis, including your estimated length of time this disability may be expected to continue? (Attach supporting documentation)

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____

Physician's Name ____ Specialty ______________________

Individual NPI # ________________________________ Tax ID # ______________________________

Street Address ____

City/State/Zip ____ Phone # __________________________

Physician's Signature ____ Date ________________

VHP INTERNAL OFFICE USE ONLY Review Date: _______________ ☐ **APPROVED** ☐ **DENIED**

Additional Notes: ____

Recertification Required: ☐ **Yes** ☐ **No** If "Yes", indicate when: ________________________

Physician's Signature ____ Date _______________