

Disabled Dependent Child Eligibility Questionnaire

If you have questions or need help completing this questionnaire, please call the Presbyterian Customer Service Center at (505) 923-5600 or toll-free at 1-888-275-7737. TTY users may call 1-877-298-7407.
 Please call Monday through Friday from 7:00 a.m. to 6:00 p.m.

**After completing this questionnaire, please mail to: Presbyterian Health Plan,
 Attn.: Enrollment Department, P.O. Box 27489, Albuquerque, NM 87125-7489**

SECTION 1: Member Information			
Subscriber Name (Last, First, Middle Initial):		Date (MM/DD/YY):	
Subscriber's ID Number:		Subscriber's Group Number:	
SECTION 2: Disabled Dependent Child Information (To be completed by Subscriber)			
Full Name of dependent child:		Date of Birth (MM/DD/YY):	
Child's relationship to Subscriber : <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other:		Dependent Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Child's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single
1. Does the dependent child rely on you for support? If "yes," what kind of support do you provide?			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the dependent child claimed as a "Dependent" for tax purposes?			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the dependent child live in your household?			<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the dependent child employed? If "yes", please complete below. Employer Name: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time			<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Work (please describe):			
5. How does the dependent child support him/herself? Please explain.			
6. Does the dependent child receive or qualify for disability income? If "yes," please attach supporting documentation.			<input type="checkbox"/> Yes <input type="checkbox"/> No
SECTION 3: Physician's Report (To be completed by Primary Care Physician/Specialist)			
Primary Care/Specialist Name (Include Degree):		Phone Number:	
Address:	City:	State:	ZIP:
1. Diagnosis/Diagnoses:			
2. Physical/behavioral limitations:			
3. Current Treatment(s) and /or Medication(s):			
4. Is this dependent child disabled or incapable of self-support?			<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is this condition permanent or expected to improve? <input type="checkbox"/> Permanent <input type="checkbox"/> Improve			
_____ Primary Care/Specialist Signature		_____ Date	
For Presbyterian Use Only			
Medical Director Decision: <input type="checkbox"/> Approved <input type="checkbox"/> Denied		Duration:	
Medical Director Reviewer:		Date:	