

# Anthem Blue Cross Request to Continue Dependent Coverage



Your request cannot be processed if any information is missing.

## Section 1: Subscriber information

Last name		First name		M.I.	Member ID no.	
Street address			City		State	ZIP code
Phone no.	Employer name			Group no.		

## Section 2: Dependent information

Last name		First name		M.I.	Date of birth (MMDDYYYY)	
Social Security no.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single		Relationship to subscriber	
Type of impairment or injury					Date of impairment or injury	
Does the subscriber claim the dependent for income tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Does the dependent live with the subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If no to either question, please explain: _____						

## Section 3: Additional insurance policies for this dependent

Does the dependent have another health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Will your Anthem policy replace their other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes to either question, complete the following.						
Other plan's policyholder name			Date of birth (MMDDYYYY)		Policy no.	
Health insurance company name			Other plan phone no.		Other plan group no.	
RX Bin	RX PCN		Date coverage started		Date coverage ended	
How did they get these benefits? <input type="checkbox"/> Through employer <input type="checkbox"/> As individual <input type="checkbox"/> Another way – describe: _____						
Is the dependent currently receiving Social Security benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, what was the effective date? _____			If no, have benefits been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No			

## Medicare – Answer these questions if their other health plan is Medicare.

Name of Medicare cardholder	Medicare claim ID/no.	Effective dates for each part	Medicare entitlement reason
		A: _____ B: _____ C: _____	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD*

\*If ESRD (kidney or renal failure) is the primary reason for Medicare, provide the date of first dialysis treatment: \_\_\_\_\_  
and transplant date if applicable: \_\_\_\_\_

## Signature required

<b>I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.</b>	
Signature of subscriber <b>X</b>	Date (MMDDYYYY)

**Section 4: Diagnosis/Prognosis – Must be completed and certified by a physician.**

Diagnosis		ICD-10 code(s)	
Describe the dependent's limitations in performing daily activities and ability to manage their affairs			
In your opinion, is the above named dependent currently incapable of self-sustained employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In your opinion, will the dependent ever be capable of self-sustained employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," provide estimated date of return to full functionality: <input type="text"/> (MMDDYYYY)			
Physician name		Physician signature <b>X</b>	Date (MMDDYYYY)
Physician street address		City	State ZIP code