

# Physician Form for Disabled Dependent



MR Type - for internal use only

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME
SUBSCRIBER'S ADDRESS (Street)		CITY STATE ZIP CODE
ID NUMBER	GROUP NAME	GROUP/DIVISION NUMBER

**This form should be completed and signed by the primary treating physician for the dependent named above.**

**Please e-mail or fax the completed form to: [provisionaladulthandicappedreview@cigna.com](mailto:provisionaladulthandicappedreview@cigna.com) or Fax: 1-866-945-7220**

## Treating Physician Information:

Physician Name: \_\_\_\_\_  
Specialty: \_\_\_\_\_ License Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Diagnosis(es) (ICD- 10): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

## B. Disabled Dependent :

Please complete this section of the form if the patient is requesting certification of disabled status. Please answer the following questions and describe, in as complete a manner as possible, the extent of your patient's behavioral, cognitive and/or physical impairment which prevents gainful employment. This information will assist Cigna HealthCare in determining this patient's eligibility for continued medical and/or dental coverage as a disabled dependent.

1. What is the patient's diagnosis?

- \_\_\_\_\_
2. When was the patient's condition initially diagnosed? \_\_\_\_\_
3. How long have you treated the patient for the specific conditions which impact his/her ability to be gainfully employed? Number of years \_\_\_\_\_ Frequency of visits \_\_\_\_\_
4. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months? \_\_\_\_\_
5. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? \_\_\_\_\_
6. Has the patient had an IQ Test? ☐ Yes ☐ No  
If Yes, what was the result? \_\_\_\_\_
7. Describe any cognitive or psychological impairment and the impact created on personal life skills and social interaction.

## Physician Form for Disabled Dependent (*Continued*)

8. Please provide objective abnormal physical examination findings (e.g. neurological deficit, contractures, loss of joint motion, etc.).

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9. Please provide objective physical examination findings:

- 
10. Please provide any pertinent recent diagnostic test results:

- 
11. Please identify any functional limitations that impair self-sustaining employment:

- 
12. Is the condition permanent? ☐ Yes ☐ No

If no, when do you anticipate that your patient will be capable of self-sustaining employment?

☐ 3 months ☐ 6 months ☐ 1 year ☐ more than 1 year

13. Is this patient in a training or other educational program to achieve the skills necessary to reach self-sustaining employment? ☐ Yes ☐ No

If Yes, when do you anticipate that your patient will be capable of self-sustaining employment?

☐ 3 months ☐ 6 months ☐ 1 year ☐ more than 1 year

 Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

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