

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 Fairfax County Public Schools	GROUP/DIVISION NUMBER 3345183

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 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?

- When was the patient's condition initially diagnosed? _____
- 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 _____
- How many hospital admissions have occurred for this diagnosis/condition in the past 12 months? _____
- How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? _____
- Has the patient had an IQ Test? Yes No
If Yes, what was the result? _____
- 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:
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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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