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
	Fairfax County Public Schools	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?

_____

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.

Please Continue on Next Page

Physician Form for Disabled Dependent *(Continued)*

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

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: _____