HIGHMARK WEST VIRGINIA

DISABLED CHILD APPLICATION

INSTRUCTIONS

1. Parent should complete the first page of the form, enter information on the first line on page two and then forward to the doctor who treats your child for this disability to complete the second page. Please mail or fax the completed form as instructed on page two.
2. Incomplete applications will be returned.
3. Highmark Blue Cross Blue Shield West Virginia (Highmark WV) has final approval on all applications.

SECTION ONE - CUSTOMER INFORMATION

Customer's Last Name (last name of parent)	First Name	Middle Initial	Telephone Number (include area code)

Customer's Address (street, city, state, zip code)

Identification Number	Account Number or Employer Name	Do you and/or another parent provide more than 50% support for this dependent? ☐ Yes ☐ No

SECTION TWO - DEPENDENT INFORMATION

Dependent's Last Name	First Name	Middle Initial	Marital Status ☐ Single ☐ Married

Dependent's Birth Date	Dependent's Relationship To Customer ☐ Son ☐ Daughter ☐ Other *(explain)*:	Dependent's Address (If different than above)

Is dependent employed? ☐ Yes ☐ No	If Yes, Name of Employer	Hours Worked _____ Per week	Rate of Pay $_____ Per hour	Type of Work Performed

Is this dependent eligible for coverage under another health plan? ☐ Yes ☐ No	If **Yes**, Please explain. If Plan is with Highmark WV, provide ID Number.
Is this dependent eligible for Medicare? ☐ Yes ☐ No	If **Yes**, provide Medicare Claim Number and Part A and Part B Effective Date.
Is this dependent eligible for Medicaid? ☐ Yes ☐ No	If **Yes**, provide Medicaid Number and Effective Date.

Has child been covered by parent continuously prior to (and after if applicable) reaching the maximum dependent child age? ☐ Yes ☐ No
If yes, and carrier was not Highmark WV, please provide HIPAA certificates of coverage to show child was continuously insured.

SECTION THREE - TERMS AND SIGNATURE

I REQUEST COVERAGE FOR THE DEPENDENT CHILD NAMED ABOVE WHO IS DISABLED.

I understand and agree that:

1. Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Blue Cross Blue Shield West Virginia.
2. I certify that all representations and information supplied by me are true. My coverage shall be void if any part of this application is false or incomplete.
3. I authorize any hospital, physician, professional review organization and any and all other providers of service to disclose and furnish to Highmark Blue Cross Blue Shield West Virginia and/or its agents any and all records relating to the disabled child named in this application for whom services or benefits have been sought or to whom services or benefits have been provided, including a complete diagnosis and medical information.
4. Attestation/Affidavit:

   I certify that the above information is true and correct to the best of my knowledge, information and belief. I understand that providing false, inaccurate or misleading information could result in recission of coverage, claim denial, and/or legal action against me by Highmark WV or my employer. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I HAVE READ AND DO AGREE TO THE ABOVE TERMS	Date
Signature of Customer: X Printed Name:	

IMPORTANT!

PLEASE HAVE PHYSICIAN COMPLETE THIS SIDE OF THIS APPLICATION.

DISABLED CHILD APPLICATION

Dependent's Last Name	First Name	Middle Initial	Dependent's Birth Date

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Physician's Name	
Physician's Address (street, city, state, zip code)	
Physician's Telephone Number (include area code)	
Diagnosis of Condition Causing Disability (Indicate degree of severity)	
Is this disability permanent? ☐ Yes ☐ No	If No, will the disability last at least twelve months? ☐ Yes ☐ No
Current medications or treatment for this disability	
Treatment or services that may be needed in the near future for this disability	

Date child was last treated (month, day, year)	Is child incapable of self-support by reason of a mental/physical disability? ☐ Yes ☐ No	If Yes, date child became incapable of self-support (month, day, year)
Is child confined in an institution? ☐ Yes ☐ No	If **Yes**, Name of Institution	

Signature of Physician:	**Please Print Name:**	Date

INSTRUCTIONS

1. The form needs to be completed in its entirety (front and back pages).
2. Please see eligibility requirements for a disabled child at the top of page 1.
3. Send this form to:

Medical Underwriting Department
614 Market Street
Parkersburg, WV 26102

Or fax the form to: 1-412-207-1446

FOR HIGHMARK WV USE ONLY

Visit our website: www.highmarkbcbswv.com

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.