

New Mexico Public Schools Insurance Authority



**Blue Cross and Blue Shield
of New Mexico**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association.

Impaired Dependent Certification

Complete this form and return to your employer's benefit office if the following situation applies to you:

1. Your dependent who is mentally or physically impaired is 24 years old and currently on your health plan. Please submit this form the month before your dependent turns age 25.

Part 1 (To be completed by Employee)

Employee's Last Name, First, Middle Initial:	Employee's Social Security Number:
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Mailing Address:

Dependent's Last Name, First, Middle Initial:	Dependent's Date of Birth:	Dependent's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
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When did the impaired status occur? _____

Provide details: _____

Is dependent reliant on you for support? Yes No

If yes, what percentage of support do you contribute?

Was dependent ever employed? Yes No Is dependent employed now? Yes No

(If yes, write name and address of current or last employer.)

Summary of any institutional care (names of institutions and dates):

Nature of care:

Part II (To be completed by the attending physician) (List multiple physicians on separate sheet of paper)

Note: The applicant is responsible for the completion of this form without expense to the insurance carrier.

Is this dependent incapable of self-sustaining employment because of mental or physical impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No	May the dependent be employed in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Questionable
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Nature and cause of incapacity:	Date of onset:
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Prognosis:	Please indicate results of any intelligence test:
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Physician Name: _____
Type or Print

Physician's Signature: _____

Physician's Degree: _____

Telephone Number: _____

Physician's Mailing Address: _____

Part III (To be completed by the School Benefits Administrator)

School Name: _____

School Address: _____

Contact Person (Employee's Benefit Specialist): _____

Phone Number: _____ Date: _____

Part IV (To be completed by NMPSIA Eligibility Administrator)

Effective date of Employee's Insurance: _____

Effective date of dependent coverage: _____

Has Employee's dependent coverage been continuously in effect up to the present date? Yes No

Please explain:

NMPSIA Eligibility Representative: _____

Phone Number: 1-800-233-3164

Date: _____

Comments:

Eligibility Representative Signature: _____

Date: _____