BlueCross BlueShield of New Mexico

Request for Coverage for Mentally or Physically Impaired Dependents

Use this form if the dependent is incapable of self-support because of mental or physical impairment. Complete and return the form within 7 days to Blue Cross and Blue Shield of New Mexico P.O. Box 27630, Albuquerque, New Mexico, 87125-7630. Please call 1-800-432-0750 with questions.

Please type or print.

Section 1 (To be completed by dependent's parent or guardian.)

Name and address of dependent's parent or guardian

Name of dependent	Dependent's birth date	Dependent's marital status Single Widowed Married Divorced

Was dependent ever institutionalized? (If yes, write name and address of institution and period(s) of confinement.)
Yes No

Is dependent eligible for care under federal, state, or local laws? (If yes, write details.)
Yes No

Was or is dependent employed for wages? (If yes, write name and address of current or last employer and average weekly earnings.)
Yes No

If dependent is no longer employed, write reason for termination.

Did the impaired status exist on dependent's 19th birthday? Yes No	Is the dependent listed as a "dependent" on your federal income tax return? Yes No	
Identification number	Group number	Signature of parent or guardian Date

Section 2 (To be completed by attending physician.)

Dependent is presently incapable of self-sustaining employment by reason of: Mental impairment Physical impairment	Is incapacity congenital? Yes No	In your opinion, will dependent ever be capable of self-sustaining employment? Yes No

Diagnosis of condition causing impaired status

Remarks (Please indicate as much detail as you think will be helpful.)

Name and address of attending physician

Signature of Physician

Date

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