Disabled Dependent Child Eligibility Questionnaire

If you have questions or need help completing this questionnaire, please call the Presbyterian Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219. TTY users may call 1-877-298-7407. Please call Monday through Friday from 7:00 a.m. to 6:00 p.m.

**After completing this questionnaire, please mail to: Presbyterian Health Plan,
Attn.: Enrollment Department, P.O. Box 27489, Albuquerque, NM 87125-7489**

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| **SECTION 1: Member Information** |
| Subscriber Name (Last, First, Middle Initial): | Date (MM/DD/YY): |
| Subscriber’s ID Number: | Subscriber’s Group Number: |
| **SECTION 2: Disabled Dependent Child Information (To be completed by Subscriber)** |
| Full Name of dependent child: | Date of Birth (MM/DD/YY): |
| Child’s relationship to Subscriber : 🞏 Parent 🞏 Guardian 🞏 Other:  | Dependent Child’s Gender: 🞏 Male 🞏 Female | Child’s Marital Status:🞏 Married 🞏 Single |
| 1. Does the dependent child rely on you for support? If “yes,” what kind of support do you provide?
 | 🞏 Yes 🞏 No |
| 1. Is the dependent child claimed as a “Dependent” for tax purposes?
 | 🞏 Yes 🞏 No |
| 1. Does the dependent child live in your household?
 | 🞏 Yes 🞏 No |
| 1. Is the dependent child employed? If “yes”, please complete below.
 | 🞏 Yes 🞏 No |
| Employer Name: | 🞏 Full Time 🞏 Part-Time |
| Type of Work (please describe): |
| 1. How does the dependent child support him/herself? Please explain.
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| 1. Does the dependent child receive or qualify for disability income? If “yes,” please attach supporting documentation.
 | 🞏 Yes 🞏 No |
| **SECTION 3: Physician’s Report (To be completed by Primary Care Physician/Specialist)** |
| Primary Care/Specialist Name (Include Degree): | Phone Number: |
| Address: | City: | State: | ZIP: |
| 1. Diagnosis/Diagnoses:
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| 1. Physical/behavioral limitations:
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|  |
| 1. Current Treatment(s) and /or Medication(s):
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|  |
| 1. Is this dependent child disabled or incapable of self-support?
 | 🞏 Yes 🞏 No |
| 1. Is this condition permanent or expected to improve?
 | 🞏 Permanent 🞏 Improve |
|  |  |  |  |  |
|  | Primary Care/Specialist Signature |  | Date |  |
|  |
| **For Presbyterian Use Only** |
| Medical Director Decision: 🞏 Approved 🞏 Denied | Duration: |
| Medical Director Reviewer: | Date: |