Health Alliance Plan®
by Henry Ford Health

Incapacitated Dependent Attestation Form

SECTION I: To be Completed by the Subscriber

1. Subscriber Name _____ Health Plan ID Number _____

2. Subscriber Address _____ Subscriber phone number: _____

3. Dependent's Name _____ Dependent's Birth Date ____ / ____ / _____

4. Dependent's Relationship to Subscriber _____

5. Dependent's Address _____

6. Name(s) of Condition _____

7. First Treatment of the Condition (month/year) _____ / _____

8. Most Recent Treatment of the Condition (month/year) _____ / _____

9. Attend School ☐ Yes. Part-time (hours per week)_____ Full-time_____

☐ No. If no, why not_____

10. Able to work ☐ Yes. Presently working at_____ Hours per week_____

☐ No. If no, why not _____

How does the condition prevent him/her from working? _____

When last worked_ Where last worked _____

Description of work _____

11. Has the dependent applied for supplemental security income (SSI) or social security disability (SSDI)? ☐ Yes ☐ No

12. Has the dependent been found eligible as disabled by supplemental security income (SSI) or social security disability insurance (SSDI)? ☐ Yes ☐ No

If yes, documentation is required to evaluate disabled dependent coverage. (Example: Notice of award letter) ☐ Yes ☐ No

13. The dependent listed above is my natural child, stepchild or adoptive child. ☐ Yes ☐ No

All questions must be answered completely for application to be processed.

I authorize medical release of information to HAP medical directors for review and I attest to the accuracy of the information contained within this form.

Signature of Subscriber_____ Date _____ /_____ /_____

Attestation

SECTION II: To be Completed by the Primary Care Provider Responsible for Treating the Condition

1. Patient Name _____

2. Date of first visit with the patient _____ /_____ /_____

3. Date of most recent visit with the patient _____ /_____ /_____

4. Diagnosis_____

5. To your knowledge, length of time this condition has existed_____

6. Indicate date that the condition resulted in marked and severe functional limitations such that the dependent became unable to attend school, live, or function independently on a daily basis __ /_____ /_____

Please describe _____

7. From the time of the first visit, the condition has □ Improved □ Remained Stable □ Deteriorated □ Not remained in evidence. Description of physical and/or mental condition and the functional impairments _____

_____

8. In your professional opinion, is this dependent described above, physically and/or mentally capable of returning to school or work? (this information is required to evaluate dependent's coverage)

□ Yes. Please indicate how many hours per week_____

□ No. If no, please attach any relevant medical documentation, including office notes, progress reports, and treatment plans that supports disability status and incapability of financial self-support or describe below:

_____

_____

9. In your professional opinion, does the condition/disability appear to be:

□ Permanent □ Temporary, Length of time_____ □ No Longer In Evidence

Section II of this document has been completed by (print) _____ , the dependent's doctor or treating provider and is accurate to the best of his/her ability.

Office Address_____ City_____ State____ Zip_____

Office Telephone Number_____ Office Fax Number_____

Physician Signature _____ Date_____ /_____ /_____

Physician's Specialty_____

Provider ID number (if applicable): _____

Mail both sections of this form to:
Health Alliance Plan
Attention: Membership and Billing
1414 E. Maple
Troy, MI 48083