MICHIGAN CARE
A PHP Health Plan

Physicians Health Plan
PO Box 30377
Lansing, Michigan 48909-7877

833.484.8450 phone
517.364.8411 fax

MichiganCare.com

Please complete the application on page 2 if you are a University of Michigan employee or retiree with a Michigan Care health plan who would like to continue coverage for a disabled dependent.

Disabled dependents are unable to earn a living because of a developmental or physical disability and must depend on their parents for support and maintenance.

Incapacitated children of University of Michigan employees and retirees are those who are totally and permanently incapacitated due to mental or physical disability, unable to earn a living due to the disability and must rely on their parents for support and maintenance. For more information on incapacitated children guidelines, please visit hr.umich.edu/benefits-wellnesss.

If your child meets these guidelines, please complete and sign page 2 of this application. Your child's physician must complete and sign page 3 of this application. Note: If you're applying for more than one dependent (for example, to apply for twins), you must complete and mail a separate application for each child. Send the completed application to Physicians Health Plan, Attn: Customer Service, PO Box 30377, Lansing, MI 48909-7877.

Once we receive your application, we'll review and determine if your child can continue under your health coverage as an incapacitated dependent. If your child does not meet the guidelines above, they will be considered ineligible and will be removed from your coverage.

For questions about incapacitated eligibility, please call the SSC Contact Center at 734.615.2000 or call 866.647.7657.

Please contact Michigan Care Customer Service at 833.484.8450 with any questions.

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INCAPACITATED DEPENDENT VERIFICATION FORM

SECTION A: INFORMATION ABOUT THE SUBSCRIBER

SUBSCRIBER'S NAME:			**MICHIGAN CARE ID NUMBER:**
ADDRESS:			**GENDER:** ☐ MALE ☐ FEMALE
CITY:	**STATE:**	**ZIP:**	**DATE OF BIRTH:**
DAYTIME PHONE NUMBER:		**EVENING PHONE NUMBER:**	

SECTION B: DEPENDENT INFORMATION

DEPENDENT'S NAME:			**MICHIGAN CARE ID NUMBER:**
DOES THE DEPENDENT LIVE WITH YOU? ☐ YES ☐ NO	**IS THE DEPENDENT MARRIED?** ☐ YES ☐ NO		**GENDER:** ☐ MALE ☐ FEMALE
IS THE DEPENDENT EMPLOYED? ☐ YES ☐ NO ☐ FULL-TIME ☐ PART-TIME			**DATE OF BIRTH:**
IF EMPLOYEED, OCCUPATION:	**IF EMPLOYEED, NAME OF EMPLOYER:**		
IS THE DEPENDENT COVERED BY MEDICARE? ☐ YES ☐ NO **POLICY NO.**		**DO YOU PROVIDE MORE THAN HALF OF THE DEPENDENT'S SUPPORT?** ☐ YES ☐ NO	
DATE CONDITION DEVELOPED:	**DIAGNOSIS:**		

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IS THE DEPENDENT CURRENTLY COVERED BY HEALTH INSURANCE OTHER THAN MICHIGAN CARE OR MEDICARE? ☐ **YES** ☐ **NO** **IF YES, PLEASE COMPLETE BELOW.**		
NAME OF INSURED:	**INSURANCE COMPANY NAME:**	
INSURANCE COMPANY ADDRESS		
GROUP OR POLICY NUMBER	**CONTRACT TYPE** ☐ **FAMILY** ☐ **INDIVIDUAL**	**POLICY EFFECTIVE DATE:**
ADDITIONAL INFORMATION:		

SECTION C: VERIFICATION

I am requesting that the dependent listed above be included under my Michigan Care health insurance plan.

- My dependent relies on me for support and maintenance.
- My dependent is incapable of self-support because of a physical or mental incapacity that existed prior to the end of the month he/she turned age 26.

I certify that I have read the entire application. I also certify that the statements and answers given are complete and correct to the best of my knowledge. I have provided supportive documentation on my dependent's disability as requested above and am aware that without proper documentation, coverage may be denied. I am also aware that additional information may be required to determine coverage, and that presenting this documentation does not imply automatic coverage.

SUBSCRIBER'S SIGNATURE DATE RELATIONSHIP TO DEPENDENT

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SECTION D: DEPENDENT'S PHYSICIAN CERTIFICATION

Please note: This section must be filled out by the dependent's attending physician. Medical records from the most recent examination must be included.

DATE OF FIRST EXAMINATION:	DATE OF LAST EXAMINATION:	FREQUENCY OF VISITS:
DIAGNOSIS/DISABILITY (INCLUDE ICD10 CODE):		
CLINICAL INFORMATION (MEDICAL SUMMARY DOCUMENTING ALL ITEMS LISTED CAN BE ATTACHED TO FORM IN LIEU OF COMPLETING THIS SECTION):		
ONSET (SPECIFIC DATE):	TEST OR DATA ESTABLISHING DIAGNOSIS:	
OTHER MEDICAL PROBLEMS:		
CURRENT MEDICATIONS AND TREATMENT PLAN (INCLUDE EXPECTED DURATION):		
IS THIS A PSYCHIATRIC DISABILITY? ☐ YES ☐ NO	IF YES, PLEASE COMPLETE THIS SECTION AND ADDRESS THESE ITEMS IN YOUR NARRATIVE REPORT: COMPLETE DSMTV DIAGNOSIS REQUIRED WITH DESCRIPTORS, CODES AND SEVERITY SPECIFIERS:	
☐ AXIS 1 ☐ AXIS II ☐ AXIS III ☐ AXIS IV ☐ AXIS 5 GAF, CURRENT GAF, HIGHEST PAST YEAR		
IS THE DEPENDENT ABLE TO INDEPENDENTLY MANAGE HIS OR HER OWN FINANCES? ☐ YES ☐ NO		
IS THE DEPENDENT FULLY COMPLIANT WITH TREATMENT? ☐ YES ☐ NO IF NO, PLEASE EXPLAIN: WOULD PROGNOSIS BE DIFFERENT IF THE DEPENDENT WERE COMPLIANT? ☐ YES ☐ NO		
HAS THE DEPENDENT BEEN HOSPITALIZED FOR A PSYCHIATRIC CONDITION? ☐ YES ☐ NO FACILITY AND DATES:		
WHAT IS THE NATURE AND DEGREE OF THE DEPENDENT'S IMPAIRMENT IN THEIR CAPACITIES FOR: DAILY ACTIVITIES? TASK PERFORMANCE? SOCIAL INTERATION?		
IF DISABILITY INVOLVES DEVELOPMENTAL DELAY OR INTELLECTUAL DETERIORATION, HAS IQ TESTING BEEN PERFORMED? ☐ YES ☐ NO DATE TESTING WAS PERFORMED:		

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IF NOT, WHAT INTELLECTUAL FUNCTIONS CAN BE PERFORMED, E.G. MATH, READING, COMPREHENSION, MEMORY SKILLS)

IS THE DEPENDENT: ☐ **AMBULATORY** ☐ **NON-AMBULATORY** ☐ **BED CONFINED**

☐ **WHEELCHAIR CONFINED** ☐ **HOUSE CONFINED** ☐ **HOSPITAL/INSTITUTION CONFINED – IF SO, NAME:**

PROGNOSIS OF TOTALLY DISABLING CONDITION:

PERMANENT AND TOTAL _____ **PERMANENT AND PARTIAL PERCENTAGE**
NOTE: PERIODIC RE-VERIFICATION WILL BE REQUIRED.

TEMPORARILY DISABLED WITH EXPECTED RETURN TO FULL FUNCTION (%) RETURN DATE: _____

TEMPORARILY DISABLED WITH EXPECTED RETURN TO PARTIAL FUNCTION (%) RETURN DATE: _____

IS THE DEPENDENT CAPABLE OF SUPPORTING HIMSELF/HERSELF THROUGH GAINFUL EMPLOYMENT?
☐ **YES** ☐ **NO**

SECTION E: PHYSICIAN VERIFICATION

I certify that the above statements are relative to the disabled dependent named on the front page are true and complete to the best of my knowledge and belief.

PHYSICIAN'S SIGNATURE LICENSE NUMBER: | PRINTED NAME | ADDRESS: | SPECIALTY

Please return request to:

Physicians Health Plan
PO Box 30377
Lansing, MI 48909-7877
Fax 517.364.8411
Email: Send securely through the Michigan Care website.
Visit MichiganCare.com.

FOR HEALTH PLAN USE ONLY		
ACCEPTED ☐	**DATE LOGGED:**	**REVIEWED BY:**
DENIED ☐		**IF DENIED, WHY:**

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LANGUAGE ASSISTANCE

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1.800.832.9186 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.832.9186 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: TTY: 711) .800.832.9186

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1.800.832.9186 (TTY: 711)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.832.9186 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.800.832.9186 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.800.832.9186 (TTY: 711) まで、お電話にてご連絡ください

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

.800.832.9186 (TTY: 711) 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.800.832.9186 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.832.9186 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.832.9186 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.832.9186 (TTY: 711).

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1.800.832.9186 (TTY: 711)

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.800.832.9186 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1.800.832.9186 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Syriac:

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܡܨܝ ܒܬܘܢ ܕܦܠܚܝܬܘܢ ܒܝܠܦܬܐ ܕܡܢܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1.800.832.9186 (TTY: 711)