

TO BE COMPLETED BY THE SUBSCRIBER

After completing the following section, please forward this form along with the enclosed envelope to your physician for his or her completion.				
1. Subscriber's Last Name		First Name		M.I.
2. Home Address		City		State
3. Group Name		3a. Group Number		
4. Dependent's Name		4a. Dependent's Birth Date		4b. Dependent's Marital Status
5. Does the dependent qualify to be claimed on your federal income tax return? ☐ Yes ☐ No				
6. Is dependent employed? ☐ Yes ☐ No		6a. Date of Hire		6b. Number of hours employed per week.
6c. Describe nature of duties				
I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.				
_____ Subscriber's Signature			_____ Date Signed	

TO BE COMPLETED BY ATTENDING PHYSICIAN

An unmarried dependent child who is incapable of self support due to a continuously disabling illness or injury may be continued as a family member on the parent's Anthem Blue Cross Contract. Your medical statement will help us determine the eligibility of this dependent.			
Please return the completed form to ANTHEM BLUE CROSS in the enclosed envelope.			
1. List the ICD9 codes relevant to the disabling condition			
2. Describe the disabling condition			
3. To what extent does the disability limit normal activity?			
4. What is your prognosis, including your estimates of length of time this disability may be expected to continue?			
Physician's Name		Physician's Signature	
Physician's Address		City	State
			ZIP Code