Dear Subscriber,

In order to verify your dependent's eligibility as a disabled adult dependent, please return the following information to Harvard Pilgrim Health Care (HPHC):

1. A completed "Subscriber Section – HPHC Disabled Adult Dependent Evaluation" form.

2. All relevant medical records related to the dependent's disability.

   Note: The enclosed "Member Authorization to Obtain Protected Health Information" form should be signed by the applying dependent and forwarded to the treating physician for the purpose of obtaining medical records.

3. A completed "Physician Section – HPHC Disabled Adult Dependent Evaluation" form.

All of the above materials are required and must be returned to:

Harvard Pilgrim Health Care
Disability Verification – Account Services
1600 Crown Colony Drive
Quincy, MA 02169

In Connecticut, the above materials must be provided within 31 days of the disabled adult dependent's loss of eligibility after turning age 26.

All medical records will be kept confidential and will only be used to determine disabled adult dependent eligibility. Any costs associated with the reproduction of medical records are the responsibility of the applicant.

If you have any questions, please call the Member Services Department at 1-888-333-4742, weekdays between 8:00 a.m. and 5:30 p.m. If you are deaf or hard-of-hearing, please call 1-800-637-8257 for TTY service.

Sincerely,

Member Services Department

Harvard Pilgrim Health Care

Subscriber Section

HPHC Disabled Adult Dependent Evaluation

1. Subscriber name: ______________________________

2. Subscriber's HPHC ID # or Social Security #: ______________________________

3. Home address: ______________________________

City: ______________________________ **State:** __________ **Zip Code:** ______________

4. Dependent's Name: ______________________________ **Birth Date (MM/DD/YYYY):** ______________

5. Dependent's Social Security #: ______________________________

6. Dependent's Relationship to Subscriber: ______________________________

7. Dependent's Address: ______________________________

City: ______________________________ **State:** __________ **Zip Code:** ______________

8. Dependent's Medical Condition(s): ______________________________

9. How long has this disability existed? ☐ **Since Birth**
☐ **Other (indicate Month/Year of outset):** ______________________________

10. Most recent treatment of the condition (Month, Year): ______________________________

11. Attend School: ☐ Yes, full-time ☐ Yes, part-time (Hours per week): ______________ ☐ No

Name of School: ______________________________

12. Able to work: ☐ No ☐ Yes, company name: ______________________ Hours per week: ________

If no, how does the condition prevent him/her from working?

____

When last worked: ______________________

Company last worked: ______________________________

Description of work: ______________________________

****Please attach copy of most recent W2 or 1099 form***

13. ☐ Yes ☐ No **Has the dependent been found eligible as "disabled" by Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)? (If Yes, please attach Notice of Award Letter)**

14. ☐ Yes ☐ No **Is the dependent currently enrolled or has the dependent ever been enrolled in Medicare Part A or Part B? (If yes, please provide the Medicare Claim Number):** ______________________________

15. ☐ Yes ☐ No **The dependent listed above is the natural child, stepchild or adoptive child of my spouse or myself and is over the age of 19.**

16. ☐ Yes ☐ No **The dependent listed above resides with me or my spouse. If No, please explain:**

____

17. ☐ Yes ☐ No **Had other health insurance coverage immediately prior to the request of the new effective date.**

(Please attach a certificate of credible coverage or supply the following information):

Name of insurance carrier: ______________________________

Date previous insurance ended: ______________________

I authorize the release of medical information to HPHC and its medical directors for review and I attest to the accuracy of the information contained within this form. I understand that my dependent's enrollment is subject to HPHC approval and periodic review.

Signature of Subscriber: ______________________________ Date: ______________

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Member Authorization to Obtain Protected Health Information

Section 1: Member Information

Member's Name ______________________________ **Home Telephone:**____________________

HPHC ID # or Social Security #:______________________________ **Birth Date (MM/DD/YYYY):**______________

Home Address: ____

City: ______________________________ **State:** __________ **Zip Code:** ___________

Section 2: Information Being Requested

I hereby authorize HPHC to obtain the following information, noted below *(Be specific and include doctors/ providers names, type of information and dates.):* ***For example: HPHC may obtain records for my heart condition prior to my enrollment in the Plan from MGH from 1995 - 1998.***

____

This information may be used for the following purpose(s):

For example: To consider my application and determine if HPHC will approve my request for enrollment. (It is sufficient for a member to indicate 'at my request' if he/she elects not to detail the purpose).

Statutorily Protected Information

Please include the following type(s) of information. Such information cannot be released from your records unless you indicate your authorization by initialing the space next to each category and provide your signature below.

_____ Mental Health _____ Alcohol and Substance Abuse _____ Abortion _____ HIV Testing
_____ Physical Abuse _____ Sexually Transmitted Diseases _____ AIDS/ARC _____ Genetic Testing

I hereby authorize release of any data in my records for the categories indicated above by my initials.

____
Signature (Required)

Harvard Pilgrim Health Care

Section 3: Terms of this Authorization

Please indicate that you have read and understand the terms of this Authorization.

If you need assistance or have questions, please call 1-888-888-4742 or TTY 1-800-637-8257.

- **I understand that HPHC will not condition my treatment, enrollment or eligibility for health insurance benefits on my signing of this Authorization**
- **I understand that I may revoke this Authorization in writing at any time**
- **I understand this Member Authorization will remain in effect until the date of________________, or until I revoke it in writing, but no longer than 30 months from the date that I sign this authorization**
- **I understand that HPHC will not use or re-disclose the PHI obtained for any reason not indicated on this form**
- **I understand I have a right to receive a copy of this Authorization upon request**

I have read and understand the terms of this Authorization and I hereby authorize the use and release of my health information in the manner described in this Authorization

______________________________ ______________

Signature of Individual **Date**

____

Printed name of Individual

****Note: If this form is signed by anyone other than you, the Member Authorization is not valid unless your Designated Personal Representative documentation is on file with HPHC.**

______________________________ ______________

Signature of Designated Personal Representative (DPR) **Date**

____

Printed name of DPR

If individual is a minor, please complete the information below:

______________________________ ______________

Signature of authorized Legal Guardian **Date**

______________________________ ______________

Printed name of Legal Guardian **Relationship**

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Physician Section - HPHC Disabled Adult Dependent Evaluation

(For additional information add pages or use the back of this sheet)

1. Patient's Name: ______________________________
2. Patient's Date of Birth: ______________________________
3. Patient's HPHC ID# or Social Security: ______________________________
4. Diagnosis: ______________________________
5. Date of onset of the disability: ______________________________
6. List specific physical and/or mental restrictions:

____

7. Degree of physical disability: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
8. Degree of mental disability: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
9. Resulting hospital confinements and dates: ______________________________
10. Current plan of treatment:

____

11. Medications:

____

12. ☐ Yes ☐ No — In your professional opinion, does the disability prevent the patient from engaging in any substantial gainful activity?

Comments ______________________________

13. ☐ Yes ☐ No — In your professional opinion, could the disability improve?

13a. If yes, how long could the disability be expected to prevent the patient from engaging in any substantial gainful activity?

☐ Less than 6 months ☐ 6 to 12 months ☐ 12 to 18 months ☐ Other ____________

Remarks:

____

Please attach all relevant medical documentation, that supports the disability diagnosis, including: office notes, specialist consultations, progress reports, treatment plans.

______________________________ ______________________________

Physician's Signature Printed Name of Physician

Location and Phone Number: ______________________________

Please return questionnaire and medical records to:

Harvard Pilgrim Health Care
Disability Verification – Account Services
1600 Crown Colony Drive
Quincy, MA 02169

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