PHYSICIAN FORM FOR HANDICAPPED/DISABLED DEPENDENT

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME
SUBSCRIBER'S ADDRESS STREET: ZIP	CITY	STATE
NAME OF HEALTH PLAN:	HEALTHPLAN CODE	ID NUMBER
GROUP NAME:		GROUP DIVISION NUMBER

This form should be completed and signed by the primary treating physician for the dependent named above.

Please return the completed form to: **Dartmouth College – Office of Human Resources**
7 Lebanon Street, Suite 203
Hanover, NH 03755

Treating Physician Information:

PHYSICIAN NAME:	SPECIALTY	LICENSE NUMBER
ADDRESS:		
TELEPHONE NUMBER:	FAX NUMBER	
DIAGNOSIS (ES) (ICD-9)		

Handicapped/Disabled Dependent:

Please answer the following questions and describe, in detail, the extent of your patient's behavioral, cognitive and/or physical impairment which prevents gainful employment. This information will assist Cigna in determining this patient's eligibility for continued medical and/or dental coverage as a handicapped/disabled dependent.

1. What is the patient's diagnosis?_____

2. When was the patient's condition initially diagnosed?_____

3. How long have you treated the patient for the specific conditions which impact his/her ability to be gainfully employed? Number of years_____ Frequency of visits_____

Please complete questions 4-11 if your patient is requesting certification of handicapped/disabled status due Behavioral Health, Cognitive and/or Neurological Impairment (otherwise, skip to question 12):

4. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months?

_____

5. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? _____

6. Has the patient had an IQ test? Yes_____ No_____

7. Describe any cognitive or psychological impairment and the impact created on personal life skills and social interaction:

8. Please provide objective abnormal physical examination findings (e.g., neurological deficit, contractures, loss of joint motion, etc):

9. Please identify any functional limitations that impair self-sustaining employment:

10. Is the condition static/permanent? Yes_____ No_____
If no, when do you anticipate your patient's condition to improve?
3 months_____ 6 months_____ 1 year_____ more than 1 year_____

11. Is this patient able to participate in a training or other educational program to achieve the skills necessary to reach self-sustaining employment? Yes_____ No_____
If yes, when do you anticipate that your patient will be capable of self-sustaining employment?
3 months_____ 6 months_____ 1 year_____ more than 1 year_____

Please complete questions 12-17 if your patient is requesting certification of handicapped /disabled status due to Other Medical Impairment (e.g., Cardiac, Gastrointestinal, Musculoskeletal, Respiratory, Visual, etc.)

12. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months?_____

13. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? _____

14. Please provide objective physical examination findings:

15. Please provide any pertinent recent diagnostic test results:

16. Please identify any functional limitations that impair self-sustaining employment:

17. Is the condition static/permanent? Yes_____ No_____
If no, when do you anticipate that your patient will be capable of self-sustaining employment?
3 months_____ 6 months_____ 1 year_____ more than 1 year_____

Physician's Signature: _____

Physician's Printed Name: _____

Date: _____