Harvard Pilgrim Health Care

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:

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

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

Harvard Pilgrim Health Care
Disability Verification – Account Services
1 Wellness Way
Canton, MA 02021

Or via email to:

myserviceteam@point32health.org

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 (888) 333-4742, weekdays between 8:00 a.m. and 5:30 p.m. If you are deaf or hard-of-hearing, please call (800) 637-8257 for TTY service.

Sincerely,

Member Services Department

Harvard Pilgrim Health Care

Subscriber Section

Harvard Pilgrim Disabled Adult Dependent Evaluation

1. Subscriber Name: _____

2. Subscriber's Harvard Pilgrim 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 Harvard Pilgrim 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 Harvard Pilgrim approval and periodic review.

Signature of Subscriber: _____ Date: _____

Harvard Pilgrim Health Care

Member Authorization to Obtain Protected Health Information

Section 1: Member Information

Member's Name _____ **Home Telephone:** _____

Harvard Pilgrim ID # or Social Security #: _____ **Birth Date (MM/DD/YYYY):** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Section 2: Information Being Requested

I hereby authorize Harvard Pilgrim to obtain the following information, noted below. *(Be specific and include doctors/providers names, type of information and dates.)* ***For example: Harvard Pilgrim 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 Harvard Pilgrim 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 (888) 888-4742 or TTY (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 Harvard Pilgrim 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 Harvard Pilgrim.**

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**

Harvard Pilgrim Health Care

Physician Section – Harvard Pilgrim 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 Harvard Pilgrim 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 1 Wellness Way
Canton, MA 02021

Or to:

myserviceteam@point32health.org