



**ATTENDING PHYSICIAN'S STATEMENT  
FOR MENTALLY OR PHYSICALLY IMPAIRED  
DEPENDENT CHILD**

**MUS EB**  
Montana University System  
Employee Benefits

**PART A TO BE COMPLETED BY EMPLOYEE/PARTICIPANT**

Name of Employer or Group Health Plan (PLEASE PRINT)

Name of Employer

Name of Employee

Name of Dependent Child:

Date of Birth:

Please indicate the nature of the child's mental or physical impairment or disability:

Do you have physical custody of this child?\*  YES  NO

Do you have legal custody of this child?\*  YES  NO

Does this child reside with you on a full-time basis? \*  YES  NO

Is this child fully dependent on you for support and maintenance? \*  YES  NO

\*If you answer "no" to these questions, but you are required to provide coverage due to a court order or divorce decree for a child not in your custody or not wholly dependent upon you for support, please so indicate and provide a copy of the order requiring you to provide medical coverage for this dependent.

Does this child have any other medical coverage?  YES  NO

If the child does have other medical coverage, please indicate below:

Other Group Health Coverage (indicate plan name and plan identification number) \_\_\_\_\_

CHAMPUS/TriCare (Coverage through the United States Armed Forces)

Worker's Compensation (give name of carrier) \_\_\_\_\_

Medicaid

Medicare

Other (please describe) \_\_\_\_\_

Please indicate the child's level of education, if applicable:

Not applicable  Elementary  Junior High  High School  College  
 Vocational/Occupational Training  Special Education  Other \_\_\_\_\_

Is the child presently attending school?  YES  NO

High School  College  Vocational/Occupational Training  Special Education

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I authorize any physician, medical practitioner, hospital, clinic, pharmacy or any other health care provider, any insurance company or any government agency to disclose all information and records relating to diagnosis, treatment, medical history, physical and mental condition and evaluation or any other relevant information concerning the above-name dependent child to New West Health Services, the Plan Supervisor of my group health plan. I understand that such information will be used, now or in the future, only for purpose of determining if the above-named dependent child is or remains eligible for dependent coverage and benefits under the terms and conditions of my group health plan. I understand that any information provided will be kept confidential and will not be released to any person or organization other than the group health plan's stop-loss insurance carrier, the Plan Supervisor's employees who require such information to complete work assigned to them, to any authorized and properly identified governmental regulatory authority, as otherwise required by law or as I may further authorize. A photocopy of this authorization shall be as valid as the original. This authorization shall remain in force for as long as I remain covered under the group health plan unless I affirmatively revoke this authorization in writing. I understand that I have a right to receive a copy of this authorization upon request.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**PART B****TO BE COMPLETED BY HEALTH CARE PROVIDER**

**NOTICE TO PROVIDER:** The Plan cannot determine eligibility or process claims without sufficient information to determine if the dependent shown in PART A is eligible under the terms and conditions of the Plan. State law provides that a health care provider may disclose health care information about a patient to a third-party health care payor who requires health care information provided that the third-party payor cannot use or disclose the health care information for any other purpose and takes appropriate steps to protect the health care information. [50-16-529 (2) MCA] Please be assured that the confidentiality of the information you provide will be maintained. We have, and strictly enforce, policies concerning confidential medical information. Confidential information is provided to employees on a "must know" basis as needed to complete the work assigned to them. New West Health Services does not disclose confidential medical information without the express written permission of the party controlling the information or to a legally authorized and properly identified governmental regulatory authority unless such disclosure is (a) necessary and appropriate to complete the work assigned, (b) specifically authorized in writing by the controlling party, or (c) compelled by applicable law. Please attaché any supporting documentation which you believe will assist in determining eligibility.

**NATURE OF IMPAIRMENT/DISABILITY AND DIAGNOSIS:****HISTORY**

Is the impairment due to:  Accident  Illness  Complication of Birth/Congenital  Other \_\_\_\_\_

**DATE OF ONSET/ACCIDENT** Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**DETAILS OF IMPAIRMENT**

Is the impairment:  Mental  Physical  Developmental  Other \_\_\_\_\_  
 Is patient:  Ambulatory  Bed Confined  House Confined  Hospital Confined

Please indicated the functions/skills the patient has difficulty with:

**Mental:**  Cognitive  Limited Capacity  Comatose/Unconscious  
**Speech:**  Unable to speak  Speaks with difficulty  Speaks without difficulty  
**Ambulation:**  Unable to walk  Walks with difficulty  Walks without difficulty  
**Mobility/Dexterity:**  Unable to use arm(s)  Unable to use hand(s)

Learning (describe): \_\_\_\_\_

Daily Life Activities:  Bathing  Dressing  Feeding  Full Custodial Care Needed

Has patient been hospital confined?  Yes  No

If yes, give name and address of hospital and dates of confinement: \_\_\_\_\_

Is patient capable of attending school or receiving vocational/occupational training?  
 YES  YES, but has special needs  NO

**DATES OF TREATMENT** (including name and date(s) of any surgery, medications prescribed, therapy, etc.)

Date of first visit Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Date of most recent visit Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

How frequently do you see this patient? \_\_\_\_\_

**EMPLOYMENT**

Is this individual capable of self-supporting employment?  YES  NO

If not, please indicate reason(s): \_\_\_\_\_

Will this individual be capable of self supporting employment in the future?  YES  NO

If no, please indicate reason(s) \_\_\_\_\_

**PROGRESS AND PROGNOSIS**

Has patient  Recovered  Improved  Stayed the same  Retrogressed

Is the patient's condition expected to  Recover  Improve  Stay the same  Decline

I affirm that the above information is correct. I authorize any hospital in which confinement took place to furnish New West Health Services, full information and disclose all facts concerning the condition of the Dependent Child (patient) shown on the reverse of this form. A photocopy shall be as valid as the original.

**Name of Attending Physician (print)** \_\_\_\_\_ **Degree** \_\_\_\_\_ **Telephone#** \_\_\_\_\_

**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Signature of Attending Physician** \_\_\_\_\_ **Date** \_\_\_\_\_