SUBMISSION INSTRUCTIONS:

EMPLOYEE

Complete the Employee section of the "Disabled Adult Child Certification Form" and submit the required documentation as indicated at the top of the form.

If the Social Security Verification Form ***is*** submitted, the employee will need to do the following:

- Complete the top section of the Disabled Adult Certification Form.
- Gather the required forms:
    1. Social Security Verification Form
    2. **and** Current year IRS 1040,
    3. **and** Birth Certificate

OR,

If the Social Security Verification Form ***is not*** submitted, the employee will need to do the following:

- Take the Disabled Adult Child Certification Form to their dependent's Physician for completion
- Gather the required forms:
    1. Completed Attending Physician's section
    2. **and** Current year IRS 1040,
    3. **and** Birth Certificate

- **Lastly, submit to the fax # or the email address located at the bottom of the form.**

Prime Healthcare

DISABLED ADULT CHILD CERTIFICATION

Certification required for a Disabled Adult Child over the age of 26:

- Option 1# Current SSI Verification Form
- Option 2# IRS 1040 AND Birth Certificate AND the Completed Physicians Certification Form (attached below)

TO BE COMPLETED BY THE EMPLOYEE

After completing the following section, please forward this form to your physician for completion.		
1. Employee's Name (Last, First Middle Initial)		1a. Social Security Number
2. Home Address (Number, Street, City, State and Zip Code)		
3. Facility Name		3a. Department
4. Dependent's Name		4a. Dependent's Date of Birth
5. Does the Dependent reside in your Home? ☐ Yes ☐ No	6. Is the Dependent more than 50% dependent upon you for support? ☐ Yes ☐ No	7. Is the Dependent listed on your last Federal Income Tax Return? ☐ Yes ☐ No
8. Is the Dependent employed?	8a. Date of Hire	8b. Number of hours employed per week.
8c. 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.		
_____ Signature of Subscriber		_____ Date of Signed

TO BE COMPLETED BY ATTENDING PHYSICIAN

An unmarried dependent child who is incapable of self-support due to continuously disabling illness or injury may continue as a dependent child on Prime Healthcare's Plans. Your medical statement will help us determine eligibility of this dependent. **Please return the completed form to the Patient**		
1. List the ICD9, ICD10 codes relevant to the disabling condition		
2. Describe the disabling condition		
3. To what extend 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?		
5. Date Disability Began		
Name of Physician	Physician's Signature	Date Signed
Address of Physician	Physician NPI	Physician Phone#

Prime Utilization Fax: 833-603-0209 Email: EHPUMDepartment@primehealthcare.com