BlueChoice® HealthPlan
South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

Please return completed form to:
BlueChoice HealthPlan
Health Services, AX-325
P.O. Box 6170, Columbia, SC 29260-6170
Or send to our HIPAA compliant fax: 800-610-5685

REQUEST TO EXTEND LIMITING AGE FOR DEPENDENT CHILD

To the Policyholder:
Your schedule of benefits allows coverage for a dependent child beyond the limiting age if the child meets the definition of an incapacitated dependent as defined by BlueChoice HealthPlan policy.

An incapacitated dependent is defined as an unmarried child who is incapable of performing gainful employment or attending school due to congenital disability, illness (including mental), physical injury or intellectual deficiency, which began before the child reached the limiting age. Additionally, the child must be dependent upon the policyholder for at least 51 percent of his/her support.

The information requested on this form aids in providing BlueChoice HealthPlan the necessary information to make a coverage determination.

SECTION 1 – TO BE COMPLETED BY POLICYHOLDER

Policyholder's Name:	Member ID #:	Group #:	Name of Group:

Policyholder's Address (number, street, city, state and ZIP code):

Dependent's Name:	With whom does Dependent live?	Relationship of Dependent to Policyholder:

Dependent's Address (if not residing with Policyholder):

Please explain why Dependent doesn't live with Policyholder:

Sex: ☐ Female ☐ Male	Birthday: (Month/Day/Year)	Is Dependent married? ☐ Yes ☐ No	Date of onset of Dependent's condition:

Is Dependent intellectually challenged? ☐ Yes ☐ No If yes, please explain:

Is Dependent mentally ill? ☐ Yes ☐ No If yes, please explain:

Is Dependent physically challenged or has special needs? ☐ Yes ☐ No If yes, please explain:

Is Dependent able to: Ambulate? ☐ Yes ☐ No Speak? ☐ Yes ☐ No Feed self? ☐ Yes ☐ No
Bathe self? ☐ Yes ☐ No Dress self? ☐ Yes ☐ No Be left alone? ☐ Yes ☐ No

Does the Policyholder contribute a minimum of 51% to the total support of the Dependent? ☐ Yes ☐ No
Is Dependent incapable of self-sustaining employment? ☐ Yes ☐ No
Has Dependent ever been employed? If yes, please give: ☐ Yes ☐ No
Last date of employment: _____ Type of work: _____ Average number of hours worked per week: _____
Is Dependent currently employed? If yes, please describe: ☐ Yes ☐ No
Type of work: _____ Average number of hours worked per week: _____

Is Dependent able to attend school? ☐ Yes ☐ No If yes, is the Dependent currently attending school? ☐ Yes ☐ No
If yes, how many hours/day? _____ how many days/week?_____
If the Dependent is not currently attending school, has the Dependent ever attended school? ☐ Yes ☐ No
If yes, what was the highest grade level completed? _____
At what age and/or grade level does the Dependent currently function? _____

Please attach documentation such as school records or court orders of disability or incapacitation and/or any other pertinent information which describes the Dependent's condition.

I CERTIFY THAT INFORMATION PROVIDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY WITH RESPECT TO THIS COVERAGE EXTENSION REQUEST.

Name of Policyholder (Please print)	Signature of Policyholder	Date

SECTION 2 – TO BE COMPLETED BY ATTENDING PHYSICIAN

Patient's Name:

Diagnosis of condition causing incapacity (Please give as much detail as possible. Attach additional pages as necessary.)

Diagnosis:

Clinical description to support incapacity:

Objective findings (current signs, result of pertinent diagnosis studies):

Nature of treatment (including surgery, therapy, medications, etc.):

Is the patient intellectually impaired? ☐ Yes ☐ No If yes, please note IQ or other standardized intellectual screening result:

☐ None (IQ 85 and above) ☐ Borderline (IQ 71–84) ☐ Mild (IQ 50–70)

☐ Moderate (IQ 35–49) ☐ Severe/Profound (IQ 34 and below)

Remarks:

Is patient mentally ill? ☐ Yes ☐ No If yes, please explain:
(Include reason mental illness prevents the patient from gainful employment or attending school.)

REMARKS AND SUGGESTIONS: (Other medical conditions and any other information that would enable us to make a determination of the Dependent's incapacity.)

Please attach documentation of pertinent medical records, if necessary.

Attending Physician's Name (please print):	Attending Physician's Phone Number:
Attending Physician's Address:	Attending Physician's Signature/Date:

For BlueChoice HealthPlan use only:

Incapacitated Minor determination: ☐ Approve ☐ Deny If denial, reason: _____

_____

BlueChoice HealthPlan Medical Director: _____ Date: _____

Eligibility updated by: _____ Date: _____

Letter sent by: _____ Date: _____

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)