



COUNTY OF
Riverside
 HUMAN RESOURCES
2001 Winner IPMA Award for Excellence

MEDICAL REPORT FOR DISABLED DEPENDENT BENEFIT

MEMBER: COMPLETE ALL ITEMS, INCOMPLETE FORMS WILL BE RETURNED, CAUSING DELAY IN BENEFITS.

MEMBER PART A: The Member is to complete the information in Part A

Member Information

Dependent Information

Name: _____

Name: _____

Social Security Number (SSN): _____

Social Security Number (SSN): _____

Address: _____

Address: _____

Telephone: _____

Date of Birth: _____

PART B: DEPENDENT AUTHORIZATION: The dependent, or person authorized to act in his behalf, is to complete the information requested in Part B prior to giving the form to the physician for completion:

I hereby authorize my attending physician _____ to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for the period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, Health Plan may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that the Health Plan will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

 Signature of Dependent or

 Date

 Person authorized to act in his/her behalf

 Relationship to the dependent.

PHYSICIAN PART C: The Physician is to complete all requested information in Parts C and D. All responses must be legible. Mail this completed form to: County of Riverside Human Resources P.O. Box 1569 Riverside CA 92502.

Medical Report	
1.	I attended the patient for the current disabling medical problem or condition from _____ to _____; at intervals of _____. I last examined the patient on _____.
2.	Medical History (related to disability): _____ Date of Disability Onset: _____
3.	Diagnosis (REQUIRED): _____ ICD-9 Disease Code, Primary (REQUIRED): _____ Secondary Code(s) (if any) _____, _____, _____

Member Name: _____

Dependent Name: _____

SSN: _____

SSN: _____

Medical Report (Continued)

4.	<u>Objective Clinical Findings/Detailed Statement of Symptoms:</u> (see items 6 & 7 for additional findings)																								
5.	<u>Current Treatment(s) and/or Medication(s):</u> rendered to the patient for <u>this disability</u> : <input type="checkbox"/> The patient is not currently receiving treatment(s) and/or medication(s) for this disability. (Check, if applicable)																								
6	<p>Functional Assessment of Activities of Daily Living (ADLs): Indicate the patient's degree of physical or mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. A ten (10) indicates the patient is completely disabled in this ADL skill or ability. These functional disabilities limit the patient's capacity for self-support.</p> <table border="0"> <tr> <td>Mobility Skills</td> <td>Self-Care Skills</td> <td>Sensory Abilities</td> <td>Cognitive Abilities</td> </tr> <tr> <td>___ walking</td> <td>___ feeding</td> <td>___ hearing</td> <td>___ judgment</td> </tr> <tr> <td>___ sitting</td> <td>___ bathing</td> <td>___ seeing</td> <td>___ memory</td> </tr> <tr> <td>___ standing</td> <td>___ toileting</td> <td>___ speech</td> <td>___ planning/follow through</td> </tr> <tr> <td>___ lifting</td> <td>___ dressing</td> <td>___ touch</td> <td>___ thinking/processing information</td> </tr> <tr> <td>___ bending</td> <td></td> <td></td> <td></td> </tr> </table>	Mobility Skills	Self-Care Skills	Sensory Abilities	Cognitive Abilities	___ walking	___ feeding	___ hearing	___ judgment	___ sitting	___ bathing	___ seeing	___ memory	___ standing	___ toileting	___ speech	___ planning/follow through	___ lifting	___ dressing	___ touch	___ thinking/processing information	___ bending			
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7.	<u>Psychological/Psychiatric Assessment:</u> List specific psychological/psychiatric symptoms or behaviors, if any, that effect the patient's ADLs and limit his or her capability to be self-supporting.																								

PART D: Medical Certification of Disability and Incapacity of Self-Support: *For purposes of this benefit, a Health Plan member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e. not capable of engaging in any substantial gainful activity) due to a physical or mental disability which existed continuously prior to becoming 23 years of age.*

1. Based on your examination, does the patient currently have a physically or mentally disabling injury, illness or condition?
 ___ NO, the patient DOES NOT have a physically or mentally disabling injury, illness or condition.
 ___ YES (Please answer Question #2.)

2. In your medical or psychiatric opinion, (please SELECT A, B or C):
 ___ A. The patient's disability DOES NOT render him or her incapable of self-support.
 ___ B. The patient's disability DOES render him or her incapable of self-support but the disability should resolve or improve sufficiently for the patient to be capable of self-support by _____ (Projected date – MM/YY)

If the condition is likely to resolve or improve, make SOME "estimate" of when this will occur. Please DO NOT leave the DATE blank. Answers such as "indefinite" or "don't know" will not suffice.

- ___ C. the patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self-support within the foreseeable future (e.g. more than 5 years).

I hereby certify that, based on my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self-support, and that I am a _____, _____ licensed to practice by the State of _____. (type of Physician) _____ (Specialty, if any)

PRINT, TYPE OR STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and HIS/HER ADDRESS, TELEPHONE AND FAX NUMBERS:

Physician's name as shown on License

Original Signature of Attending Physician

Local Address

State License Number

City State

Telephone Number

Date

Fax Number

PRIVACY INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the Health Plan to provide the following information pursuant to individuals who are asked to supply information. The information requested is collected pursuant to government code (Section 20000, et seq.) and will be used for administration under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to supply the information may result in the Health Plan being unable to perform its functions regarding your status. Portions of this information may be transferred to other governmental agencies (such as your employer, physician, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.)

You have the right to review your membership files maintained by the Health Plan. For questions concerning your rights under the Information Practices Act of 1977, please contact the County of Riverside Human Resources at (909) 955-3591.

The Health Plan requests each enrollee's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other agencies for identification purposes, the Health plan may be unable to verify eligibility for benefits without the Social Security number.

The Health Plan uses Social Security account numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Coordination of benefits among health plan carriers.
3. Resolve member appeals/complaints/grievances.