



Health Benefit Services Division

P. O. Box 942714
Sacramento, CA 94229-2714

Telecommunications Device for the Deaf - (916) 326-3240
Toll Free: (800) 237-3345 Local: (916) 326-3970

MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT

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):
Address:
Telephone: ()

SSN:
Address:
Date of Birth:

PART B: DEPENDENT AUTHORIZATION: The dependent, or person authorized to act in his or her 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 a 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, CalPERS may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand CalPERS 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 CalPERS at the address found at the top of this page.

Please DO NOT send information copied directly from the patient's medical record at this time.

Dear Doctor,

The patient requests you to complete this Medical Report form. It will assist CalPERS in processing his or her claim for health insurance as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information promptly, you will help the patient expedite the claims process.

Medical Report form with 5 numbered sections: 1. I attended the patient for the current disabling medical problem or condition from to ; at intervals of . I last examined the patient on (date): 2. Medical History(related to disability): Date of Disability Onset: 3. Diagnosis (REQUIRED): ICD-9 Disease Code, Primary (Required): ICD-9 Disease Code(s), Secondary: DSM III Code(s) (if any): 4. Objective Clinical Findings/Detailed Statement of Symptoms: (see page two, Items 6 and 7 for additional findings) 5. Current Treatment(s) and/or Medication(s): (rendered to the patient for this disability): [] The patient is not currently receiving treatment(s) and/or medication(s) for this disability. (Check, if applicable.)

(See Page Two of this form for additional required information.)

MEMBER NAME: _____
 SSN: _____

DEPENDENT NAME: _____
 SSN: _____

Medical Report (Continued)				
6.	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.			
	Mobility Skills _____ walking _____ sitting _____ standing _____ lifting _____ bending	Self-Care Skills _____ feeding _____ bathing _____ toileting _____ dressing	Sensory Abilities _____ hearing _____ seeing _____ speech _____ touch	Cognitive Abilities _____ judgment _____ memory _____ planning/follow through _____ thinking/processing information
7.	Psychological/Psychiatric Assessment: 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 CaPERS 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 current disability DOES NOT render him or her incapable of self-support.

_____ B. The patient's current 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 OR 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

PART E: CaPERS USE ONLY:

_____ Claim approved for enrollment through _____
 _____ Claim rejected. DATE (for next review)

 REVIEWED BY:

 TODAY'S DATE

PRIVACY INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System (CalPERS) to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code (Section 20000, et seq.) and will be used for administration of the Board's duties 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 System being unable to perform its functions regarding your status. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians, 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 System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 492702, Sacramento, CA 94229-2702.

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency which requests an individual to disclose his/her social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

The CalPERS Health Benefit Services Division 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 Benefit Services Division may be unable to verify eligibility for benefits without the Social Security number.

The CalPERS Health Benefit Services Division uses Social Security account numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Payroll deduction and state contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plan carriers.
6. Resolve member appeals/complaints/grievances with health plan carriers.