



Arkansas Blue Cross Blue Shield
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Health Advantage
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**PROOF OF INCAPACITY OF A DEPENDENT
 PHYSICIAN'S FORM**

Subscriber Name _____ Subscriber # _____

Address _____

Dependent Name _____

The Insurer covers dependent children that have reached the maximum dependent age that are physically or mentally incapacitated. In order to make a determination, the following information must be completed. Please attach any supporting documentation.

Current Age _____ Height _____ Weight _____ Mental Incapacity _____ If Yes, Add IQ Score _____

Physical Incapacity _____ Age at onset of condition/disability _____

Describe incapacity or reason incapable of self care/self support _____

Acute Medical Conditions (describe) _____

Chronic Medical Conditions (describe) _____

Future health concerns or considerations _____

Medications, dosage, reason for medications _____

Other important facts _____

A copy of any pertinent medical information may be attached.

I have examined the dependent named above, and the degree of his/her disability or incapacity is of such a nature that he/she is incapable of self care/self support.

Physician Name _____ Specialty _____

Physician Signature _____ Date _____