North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Coverage Request for a Dependent Child with a Disability

Please Return Completed Form to:
North Carolina State Health Plan Attn: Customer Experience
3200 Atlantic Avenue Raleigh, NC 27604

SECTION A – TO BE COMPLETED BY MEMBER

NAME OF SUBSCRIBER	ADDRESS OF MEMBER	MEMBER ID NUMBER

MEMBER EMAIL ADDRESS

NAME OF DEPENDENT CHILD	SOCIAL SECURITY NUMBER OF DEPENDENT	DEPENDENT CHILD DATE OF BIRTH

IS THE DEPENDENT CHILD ELIGIBLE FOR THEIR OWN EMPLOYER SPONSORED COVERAGE? ☐ YES ☐ NO

IS DEPENDENT CHILD ELIGIBLE FOR MEDICARE? ☐ YES → **IF YES,** GIVE EFFECTIVE DATES: ☐ NO PART A EFFECTIVE DATE: PART B EFFECTIVE DATE:

SIGNATURE OF MEMBER: DATE SIGNED:

SECTION B – TO BE COMPLETED BY CERTIFYING PHYSICIAN

DATE YOU LAST SAW THE PATIENT:	IS DISABILITY CONGENTIAL? ☐ YES ☐ NO →	**IF NO,** DATE OF DISABILITY **OR** DATE OF ONSET OF DISABILITY (REQUIRED):

DIAGNOSIS OF CONDITION(S) CAUSING DISABILITY STATUS:

IS THIS PATIENT **INCAPABLE** OF SELF-SUSTAINING EMPLOYMENT FOR A PERIOD OF ONE YEAR OR LONGER? ☐ YES → IF YES, HOW LONG? ☐ LESS THAN 1 YEAR ☐ 2-5 YEARS ☐ PERMANANT ☐ NO

PLEASE PROVIDE DETAILS EXPLAINING THE DEGREE OF DISABILITY AND /OR FUNCTIONAL LEVEL, TREATMENT AND PROGNOSIS :

OFFICE MANAGER CONTACT:

NPI OF CERTIFYING PHYSICIAN:	ADDRESS:

SIGNATURE OF CERTIFYING PHYSICIAN:	DATE SIGNED:

SECTION C – FOR INTERNAL OFFICE USE ONLY

DECISION		REVIEWED BY:
APPROVED DURATION: COVERAGE CONTINUES:	DENIED COVERAGE ENDS:	DECISION DATE:

Completed forms should be mailed to:
North Carolina State Health Plan Attn: Customer Experience 3200 Atlantic Avenue Raleigh, NC 27604 or faxed to: 919-855-5817