Disabled Dependent Child Eligibility Questionnaire

If you have questions or need help completing this questionnaire, please call the Presbyterian Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219. TTY users may call 1-877-298-7407. Please call Monday through Friday from 7:00 a.m. to 6:00 p.m.

**After completing this questionnaire, please mail to: Presbyterian Health Plan,   
Attn.: Enrollment Department, P.O. Box 27489, Albuquerque, NM 87125-7489**

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| **SECTION 1: Member Information** | | | | | | | | | | | | | | | |
| Subscriber Name (Last, First, Middle Initial): | | | | | | | | | Date (MM/DD/YY): | | | | | | |
| Subscriber’s ID Number: | | | | | Subscriber’s Group Number: | | | | | | | | | | |
| **SECTION 2: Disabled Dependent Child Information (To be completed by Subscriber)** | | | | | | | | | | | | | | | |
| Full Name of dependent child: | | | | | | | | | Date of Birth (MM/DD/YY): | | | | | | |
| Child’s relationship to Subscriber : 🞏 Parent 🞏 Guardian  🞏 Other: | | | | | | Dependent Child’s Gender:  🞏 Male 🞏 Female | | | | | | Child’s Marital Status:  🞏 Married 🞏 Single | | | |
| 1. Does the dependent child rely on you for support? If “yes,” what kind of support do you provide? | | | | | | | | | | | | | | 🞏 Yes 🞏 No | |
| 1. Is the dependent child claimed as a “Dependent” for tax purposes? | | | | | | | | | | | | | | 🞏 Yes 🞏 No | |
| 1. Does the dependent child live in your household? | | | | | | | | | | | | | | 🞏 Yes 🞏 No | |
| 1. Is the dependent child employed? If “yes”, please complete below. | | | | | | | | | | | | | | 🞏 Yes 🞏 No | |
| Employer Name: | | | | | | | 🞏 Full Time 🞏 Part-Time | | | | | | |
| Type of Work (please describe): | | | | | | | | | | | | | |
| 1. How does the dependent child support him/herself? Please explain. | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | |  |
| 1. Does the dependent child receive or qualify for disability income? If “yes,” please attach supporting documentation. | | | | | | | | | | | | | | 🞏 Yes 🞏 No | |
| **SECTION 3: Physician’s Report (To be completed by Primary Care Physician/Specialist)** | | | | | | | | | | | | | | | |
| Primary Care/Specialist Name (Include Degree): | | | | | | | | Phone Number: | | | | | | | |
| Address: | | | | City: | | | | State: | | | | | ZIP: | | |
| 1. Diagnosis/Diagnoses: | | | | | | | | | | | | | | | |
| 1. Physical/behavioral limitations: | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| 1. Current Treatment(s) and /or Medication(s): | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| 1. Is this dependent child disabled or incapable of self-support? | | | | | | | | | | | | | | 🞏 Yes 🞏 No | |
| 1. Is this condition permanent or expected to improve? | | | | | 🞏 Permanent 🞏 Improve | | | | | | | | | | |
|  |  | | | | | | | | |  |  | | | |  |
|  | Primary Care/Specialist Signature | | | | | | | | |  | Date | | | |  |
|  | | | | | | | | | | | | | | | |
| **For Presbyterian Use Only** | | | | | | | | | | | | | | | |
| Medical Director Decision: 🞏 Approved 🞏 Denied | | | | | | | | | | | Duration: | | | | |
| Medical Director Reviewer: | | | | | | | | | | | Date: | | | | |