Health Net Health Plan of Oregon, Inc., "Health Net"

Disabled Dependent Certification

Subscriber information

AFTER COMPLETING THIS TOP SECTION, PLEASE FORWARD IT TO YOUR PHYSICIAN FOR HIS OR HER COMPLETION. RETURN THE COMPLETED FORM TO HEALTH NET AND MAIL TO: HEALTH NET, PO BOX 9103, VAN NUYS, CA 91409-9103.

Subscriber name – Last:	First:	MI:	Subscriber ID # (if applicable):
Address:			
City:	State:	ZIP:	Telephone #: ( )
Group name:		Group #:	
Dependent name:		Dependent birth date:	

Is your dependent child incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition? ☐ Yes ☐ No

Is your dependent child more than 50% dependent on you for support and maintenance? ☐ Yes ☐ No

I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.

Signature of subscriber: _____ Date: _____

To be completed by attending physician

A dependent child who is incapable of self-support due to a continuously disabling illness or injury may be continued as a family member on the parent's Health Net contract. Your medical statement will help us to determine the eligibility of this dependent.

Note: This is not a request for genetic information, as defined under The Genetic Nondiscrimination Act of 2008 (GINA). In response to this request, please do not provide Health Net with any of the above individual's genetic information. If the medical records we have requested contain genetic information, please be advised that GINA requires the redaction of such information prior to responding to this request. Thank you for your assistance in complying with this regulatory requirement.

Please give us specifics as to the nature of the disability. (Attach supporting documentation.)

Please specifically explain how the disability causes the patient to be incapable of working or living independently.

To what extent does the disability limit normal activity? (Attach supporting documentation.)

What is your prognosis, including your estimates of length of time this disability may be expected to continue? (Attach supporting documentation.)

Physician signature:	Name of physician:	Date signed:
Address:		
City:	State:	ZIP:

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