# *PHYSICIAN FORM FOR HANDICAPPED/DISABLED DEPENDENT*

| *MR Type - for internal use only* |
|---|

| DATE | SUBSCRIBER'S NAME (EMPLOYEE) | DEPENDENT'S NAME | |
|---|---|---|---|
| SUBSCRIBER'S ADDRESS<br>STREET: | CITY: | STATE: | ZIP CODE: |
| NAME OF HEALTH PLAN: | | HEALTHPLAN CODE: | ID NUMBER |
| GROUP NAME | | | GROUP/DIVISION NUMBER |

***This form should be completed and signed by the primary treating physician for the dependent named above.***

***Please mail the completed form to: Cigna HealthCare***
***P.O. Box 692012***
***San Antonio, TX 78269***

***Treating Physician Information:***

Physician Name:

Specialty: License Number:

Address:

Telephone Number: Fax Number:

Diagnosis(es) (ICD-9) ________, ________, ________, ________

**A. Student Medical Leave of Absence:**

Please complete this section of the form if the patient is requesting a Student Medical Leave of Absence.

Does this patient qualify for a medically necessary Student Medical Leave of Absence?
Yes_____ No_____

If yes, please provide a short explanation below:

**Please Continue on Reverse Side**

**B. Handicapped/Disabled Dependent:**

Please complete this section of the form if the patient is requesting certification of handicapped/ disabled status. Please answer the following questions and describe, in as complete a manner as possible, the extent of your patient's behavioral, cognitive and/or physical impairment which prevents gainful employment. This information will assist Cigna HealthCare in determining this patient's eligibility for continued medical and/or dental coverage as a handicapped/disabled dependent.

1. What is the patient's diagnosis?_______________________________________________

2. When was the patient's condition initially diagnosed? ___________________________

3. How long have you treated the patient for the specific conditions which impact his/her ability to be gainfully employed? Number of years________ Frequency of visits______________________

***Please complete questions 4-11 if your patient is requesting certification of handicapped/ disabled status due to Behavioral Health, Cognitive and/or Neurological Impairment (otherwise, skip to question 12):***

4. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months? _______________

5. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? _______________

6. Has the patient had an IQ test? Yes_____ No_____
   If yes, what was the result? _______________

7. Describe any cognitive or psychological impairment and the impact created on personal life skills and social interaction:

8. Please provide objective abnormal physical examination findings (e.g. , neurological deficit, contractures, loss of joint motion , etc):

9. Please identify any functional limitations that impair self-sustaining employment:

**Please Continue on Next Page**

10. Is the condition static/permanent? Yes_____ No_____
    If no, when do you anticipate your patient's condition to improve?
    3 months_________ 6 months_________ 1 year_________ more than 1 year_________

11. Is this patient able to participate in a training or other educational program to achieve the skills necessary to reach self-sustaining employment? Yes_____ No_____
    If yes, when do you anticipate that your patient will be capable of self-sustaining employment?
    3 months_________ 6 months_________ 1 year_________ more than 1 year_________

***Please complete questions 12-17 if your patient is requesting certification of handicapped/ disabled status due to Other Medical Impairment (e.g., Cardiac, Gastrointestinal, Musculoskeletal, Respiratory, Visual,etc.)***

12. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months? ______________

13. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? _____________

14. Please provide objective physical examination findings:

15. Please provide any pertinent recent diagnostic test results:

16. Please identify any functional limitations that impair self-sustaining employment:

17. Is the condition static/permanent? Yes_____ No_____
    If no, when do you anticipate that your patient will be capable of self-sustaining employment?
    3 months_________ 6 months_________ 1 year_________ more than 1 year_________

Physician's Signature: ____________________________________________________________

Physician's Printed Name: ____________________________________________________________

Date: __________________________

"Cigna," "Cigna HealthCare" and the "Tree of Life" logo are registered service marks of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company,Tel-Drug, Inc. and its affiliates, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. In Arizona, HMO plans are offered by Cigna HealthCare of Arizona, Inc. In California, HMO plans are offered by Cigna HealthCare of California, Inc. and Great-West Healthcare of California, Inc. In Connecticut, HMO plans are offered by Cigna HealthCare of Connecticut, Inc. In Virginia, HMO plans are offered by Cigna HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by Cigna HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company.