ATTENDING PHYSICIAN'S STATEMENT
FOR MENTALLY OR PHYSICALLY IMPAIRED DEPENDENT CHILD

PART A TO BE COMPLETED BY EMPLOYEE/PARTICIPANT

Name of Employer or Group Health Plan (PLEASE PRINT):

Name of Employee:

Address of Employee:

Name of Dependent Child: Date of Birth:

Please indicate the nature of the child's mental or physical impairment or disability:

Do you have physical custody of this child?* _____YES _____NO

Do you have legal custody of this child?* _____YES _____NO

Does this child reside with you on a full-time basis?* _____YES _____NO

Is this child fully dependent on you for support and maintenance?* _____YES _____NO

*If you answer "no" to these questions, but you are required to provide coverage due to a court order or divorce decree for a child not in your custody or not wholly dependent upon you for support, please so indicate and provide a copy of the order requiring you to provide medical coverage for this dependent.

Does this child have any other medical coverage? _____YES _____NO

If the child does have other medical coverage, please indicate below:
__ Other Group Health Coverage (indicate plan name and plan identification number) _____
__ CHAMPUS/TriCare (Coverage through the United States Armed Forces)
__ Worker's Compensation (give name of carrier) _____
__ Medicaid
__ Medicare
__ Other (please describe) _____

Please indicate the child's level of education, if applicable:
__ Not applicable __ Elementary __ Junior High __ High School __College
__ Vocational/Occupational Training __ Special Education __ Other _____

Is the child presently attending school? ____YES ____NO
__ High School __ College __ Vocational/Occupational Training __ Special Education

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, pharmacy or any other health care provider, any insurance company or any government agency to disclose all information and records relating to diagnosis, treatment, medical history, physical and mental condition and evaluation or any other relevant information concerning the above-named dependent child to Allegiance Benefit Plan Management, Inc., the Plan Supervisor of my group health plan. I understand that such information will be used, now or in the future, only for purpose of determining if the above-named dependent child is or remains eligible for dependent coverage and benefits under the terms and conditions of my group health plan. I understand that any information provided will be kept confidential and will not be released to any person or organization other than the group health plan's stop-loss insurance carrier, the Plan Supervisor's employees who require such information to complete work assigned to them, to any authorized and properly identified governmental regulatory authority, as otherwise required by law or as I may further authorize. A photocopy of this authorization shall be as valid as the original. This authorization shall remain in force for as long as I remain covered under the group health plan unless I affirmatively revoke this authorization in writing. I understand that I have a right to receive a copy of this authorization upon request.

Signature of Employee: _____ **Date:** _____

PART B TO BE COMPLETED BY HEALTH CARE PROVIDER

NOTICE TO PROVIDER: The Plan cannot determine eligibility or process claims without sufficient information to determine if the dependent shown in PART A is eligible under the terms and conditions of the Plan. HIPAA and applicable state laws provide that a health care provider may disclose health care information about a patient to a third-party health care payor who requires health care information provided that the third-party payor cannot use or disclose the health care information for any other purpose and takes appropriate steps to protect the health care information. Please be assured that the confidentiality of the information you provide will be maintained. We have, and strictly enforce, policies concerning confidential medical information. Confidential information is provided to employees on a "must know" basis as needed to complete the work assigned to them. Allegiance Benefit Plan Management, Inc. does not disclose confidential medical information without the express written permission of the party controlling the information or to a legally authorized and properly identified governmental regulatory authority unless such disclosure is (a) necessary and appropriate to complete the work assigned, (b) specifically authorized in writing by the controlling party, or (c) compelled by applicable law. Please attach any supporting documentation which you believe will assist in determining eligibility.

NATURE OF IMPAIRMENT/DISABILITY AND DIAGNOSIS:

HISTORY

Is the impairment due to: __ Accident __ Illness __ Complication of Birth/Congenital __Other _____

DATE OF ONSET/ACCIDENT Month _____ Day _____ Year _____

DETAILS OF IMPAIRMENT

Is the impairment: __ Mental __ Physical __Developmental __ Other _____

Is patient: __ Ambulatory __ Bed Confined __ House Confined __ Hospital Confined

Please indicate the functions/skills the patient has difficulty with:

Mental: __ Cognitive __ Limited Capacity __ Comatose/Unconscious

Speech: __ Unable to speak __ Speaks with difficulty __Speaks without difficulty

Ambulation __Unable to walk __ Walks with difficulty __ Walks without difficulty

Mobility/Dexterity __ Unable to use arm(s) __ Unable to use hand(s)

Learning (describe) _____

Daily Life Activities __ Bathing __ Dressing __ Feeding __ Full Custodial Care Needed

Has patient been hospital confined? __ YES __ NO

If yes, give name and address of hospital and dates of confinement: _____

Is patient capable of attending school or receiving vocational/occupational training?

__ YES __ YES, but has special needs __ NO

DATES OF TREATMENT (including name and date(s) of any surgery, medications prescribed, therapy, etc.)

Date of first visit Month _____ Day _____ Year _____

Date of most recent visit Month _____ Day _____ Year _____

How frequently do you see this patient? _____

EMPLOYMENT

Is this individual capable of self-supporting employment? ___ YES ___ NO

If not, please indicate reason(s): _____

Will this individual be capable of self supporting employment in the future? ___ YES ___ NO

If yes, please indicate the date the individual is expected to be able to work: _____

If no, please indicate reason(s): _____

PROGRESS AND PROGNOSIS

Has patient __ Recovered __ Improved __ Stayed the same __ Retrogressed

Is the patient's condition expected to __ Recover __Improve __ Stay the same __ Decline

I affirm that the above information is correct. I authorize any hospital in which confinement took place to furnish Allegiance Benefit Plan Management, Inc., full information and disclose all facts concerning the condition of the Dependent Child (patient) shown on the reverse of this form. A photocopy shall be as valid as the original.

Name of Attending Physician (print) _____ Degree _____ Telephone # _____

Street Address _____City _____ State _____ Zip Code _____

Signature of Attending Physician _____ Date _____

The completed form must be returned to Allegiance Benefit Plan Management. The employee will be notified by the office of Teachers Health Trust of the eligibility status.

Mail: Enrollment Department PO Box 3018 Missoula, MT 59806

Fax: 800-257-0950

Phone: 800-877-1122