Health Account Management Division
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MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT

COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING DELAY IN BENEFITS.

MEMBER PART A: The **member** is to complete the information in Part A:

MEMBER INFORMATION	DEPENDENT INFORMATION
NAME: _____	**NAME:** _____
SOCIAL SECURITY NUMBER (SSN): _____	**SOCIAL SECURITY NUMBER (SSN):** _____
ADDRESS: _____	**ADDRESS:** _____
_____	_____
PRIMARY PHONE NUMBER: _____	**DATE OF BIRTH:** _____

PART B, DEPENDENT AUTHORIZATION: The **dependent**, or person authorized to act in his or her behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion:

I hereby authorize my attending physician, _____, to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, CalPERS may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that CalPERS will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

_____ _____
Signature of Dependent **OR** Date Signed

_____ _____
Person authorized to act on his/her behalf Relationship to the dependent

PHYSICIAN PART C: The **physician** is to complete all requested information in PARTS C and D. All responses must be legible. Mail this completed form to CalPERS at the address found at the top of this page.

Please DO NOT send information copied directly from the patient's medical record at this time.

Dear Doctor:
The patient requests you to complete this **Medical Report** form. It will assist CalPERS in processing his or her claim for health insurance as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information promptly, you will help the patient expedite the claims process.

Medical Report	
1.	I attended the patient for the current disabling medical problem or condition from _____ to _____; at intervals of _____. I last examined the patient on _____.
2.	Medical History (related to disability): Date of Disability Onset: _____
3.	Diagnosis (REQUIRED): _____ ICD-9 Disease Code, Primary (Required): _____ ICD-9 Disease Code(s), Secondary: _____ DSM IV Code(s) (if any): _____
4.	Objective Clinical Findings/Detailed Statement of Symptoms: (see page 2, Items 6 and 7 for additional findings)
5.	Current Treatment(s) and /or Medication(s) (rendered to the patient for this disability): ☐ The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable.)

MEMBER NAME: DEPENDENT NAME:
SSN: SSN:

	Medical Report
6.	Functional Assessment of Activities of Daily Living (ADL): Indicate the patient's degree of physical or mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. Ten (10) indicates the patient is completely disabled in this ADL skill or ability. These functional disabilities limit the patient's capacity for self-support. **Mobility Skills**: ____ walking, ____ sitting, ____ standing, ____ lifting, ____ bending **Self-Care Skills**: ____ feeding, ____ bathing, ____ toileting, ____ dressing **Sensory Skills**: ____ hearing, ____ seeing, ____ speech, ____ touch **Cognitive Skills**: ____ judgment, ____ memory, ____ planning/follow through, ____ thinking/processing information
7.	Psychological / Psychiatric Assessment: List the specific psychological / psychiatric symptoms or behaviors, if any, that affect the patient's ADLs and limit his or her capacity to be self-supporting:

PART D, Medical Certification of Disability and Incapacity of Self-Support: For purposes of this benefit, a CalPERS member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 26 years of age.

1. Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness, or condition?

☐ NO, the patient does NOT have a physically or mentally disabling injury, illness or condition.

☐ YES (Please answer Question 2)

2. In your medical or psychiatric opinion, please select **A**, **B**, or **C**:

☐ **A** The patient's current disability DOES NOT render him or her incapable of self-support.

☐ **B** The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by _____.
PROJECTED DATE (mm/yy)

If the condition is likely to improve or resolve, make SOME estimate of when this will occur.
Please DO NOT leave the PROJECTED DATE blank. Answers such as "indefinite" or "don't know" will not suffice.

☐ **C** The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self-support within the foreseeable future (e.g., more than 5 years).

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self-support, and that I am a _____ (Type of Physician), _____ (Specialty, if any) licensed to practice by the State of _____.

PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and HIS OR HER ADDRESS, TELEPHONE AND FAX NUMBERS:

PHYSICIAN'S NAME AS SHOWN ON LICENSE

ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN

LOCAL ADDRESS

STATE LICENSE NUMBER

CITY, STATE ZIP

( ) PHONE NUMBER

DATE

( ) FAX NUMBER

PART E, CalPERS USE ONLY:

☐ Claim approved for enrollment through _____
DATE (for next review)

REVIEWED BY

☐ Claim rejected.

DATE

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).