Attending Physician's Statement
For Learning, Developmental or Physically Impaired Dependent Child

Our records indicate that you recently requested to add a dependent to your insurance coverage over the age of 26. In order for your dependent to receive benefits, you are required to submit proof of their eligibility within 31 days of the date of notification from TriHealth Benefit Solutions. **Failure to complete and return this form will result in denial of your dependent's coverage retrospectively and potential recovery of claim payments.**

Thank you for your assistance in providing this information. If you have questions or concerns, call TBS Customer Service Department at 1-833-999-4TBS (4827). Please return this form to TBS at the address or email listed at the end of the form.

PART A TO BE COMPLETED BY EMPLOYEE/PARTICIPANT (SUBSCRIBER/POLICYHOLDER)

I. SUBSCRIBER INFORMATION

Last Name	First Name, Middle Initial	Date of Birth (MM/DD/YYYY)
Group Number	Health Plan ID Number	Daytime Phone Number
Street Address	City, State, Zip	Email Address

II. DEPENDENT INFORMATION

First Name of Dependent Child	Last Name of Dependent Child	Date of Birth
Please indicate the nature of the child's learning, developmental or physical impairment or disability:	1) *Do you have physical custody of this child? ☐ Yes ☐ No 2) *Do you have legal custody of this child? ☐ Yes ☐ No 3) *Is this child fully dependent on you for support and maintenance? ☐ Yes ☐ No	4) *Does this child reside with you on a full-time basis? ☐ Yes ☐ No If no, please indicate the street address, city, state and zip with which the child resides. ________________________________ ________________________________ 5) *Is this child married? ☐ Yes ☐ No

***If you answer "no" to the first four 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 indicate and provide a copy of the order requiring you to provide medical coverage for this dependent.**

IV. 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 TriHealth Benefit Solutions, the Plan Administrator of my group health plan. I understand that such information will be used, now or in the future, only for the 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'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 SUBSCRIBER (POLICYHOLDER)	SIGNATURE OF DEPENDENT CHILD (OR LEGAL GUARDIAN)
______________________________	______________________________
DATE ____ / ____ / ____	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. State law provides 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. [50-16-529 (2) MCA] 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. TriHealth Benefit Solutions 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.

GINA DISCLAIMER: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

NATURE OF IMPAIRMENT/DISABILITY AND DIAGNOSIS

Dependent Last Name	Dependent First Name, Middle Initial	Date of Birth (MM/DD/YYYY)

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 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 no, 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

AFFIRMATION

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

Attending Physician Last Name	Attending Physician First Name	Degree
Street Address	City, State and Zip Code	Telephone Number

SIGNATURE OF ATTENDING PHYSICIAN **DATE**
____ / ____ / ____

VII. Please send the completed Form (Part A and Part B) in one of the following ways:

- Mail: TriHealth Benefit Solutions
  PO Box 211775
  Eagan, MN 55121

- Email: emailtbs@trihealth.com

Part A and Part B must be received together for Eligibility Verification Review.

TriHealth Benefit Solutions
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Cincinnati, OH 45212
TriHealthBenefitSolutions.com