BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

Post Office Box 98029 • Baton Rouge, Louisiana 70898-9029

HMO Louisiana, Inc.

A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

Post Office Box 98024 • Baton Rouge, Louisiana 70898-9024

DEPENDENT CERTIFICATION

01__________ 02__________ 03__________ 04__________

Dear Subscriber: Date:

We have recently received a claim/enrollment form/change card for the patient/dependent named below. We must have additional information before this can be processed. Please answer **all** questions, sign and return this form to us by . Failure to return the completed form by the requested date will cause your claim to be rejected, or will delay processing of your enrollment form or change card. **Completion of this form may be required periodically.**

☐ **SECOND REQUEST (IF BOX IS CHECKED)**

PATIENT/DEPENDENT NAME	DAY TIME PHONE NO.
CONTRACT NUMBER	
GROUP NUMBER	DATE OF SERVICE

FOLD

1. . . . ☐ YES ☐ NO Is dependent less than 25 years old?

DATE OF BIRTH	DATE DEPENDENCY BEGAN	SEX ☐ M ☐ F

2. . . . ☐ YES ☐ NO Is dependent married? ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

3. . . . ☐ YES ☐ NO Is dependent covered under any other insurance contract? If yes, give name of company and policy number.

NAME	POLICY NO.

4. . . . ☐ YES ☐ NO Does dependent rely upon you for financial support?

5. . . . ☐ YES ☐ NO Does dependent reside with you?

IS DEPENDENT YOUR ☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ CHILD FROM A PREVIOUS MARRIAGE ☐ OTHER (explain on other side)

6. . . . ☐ YES ☐ NO Is dependent a full time student?

NAME AND ADDRESS OF SCHOOL NOW ATTENDING

STUDENT ID NUMBER	CURRENT TERM FROM ___ TO ___	EXPECTED DATE OF GRADUATION	ORIGINAL ENROLLMENT DATE

7. . . . ☐ YES ☐ NO Has dependent been a full-time student since reaching age 21?

8. . . . ☐ YES ☐ NO Is dependent mentally or physically incapacitated? **If yes, please attach medical documentation from your doctor with an explanation of:**
   A. Diagnosis of condition(s) causing incapacitation
   B. Date patient/dependent first became incapacitated
   C. Anticipated length of incapacitation
   ☐ Additional information needed

CERTIFICATION BY SUBSCRIBER - READ CAREFULLY - THIS SECTION MUST BE SIGNED BY SUBSCRIBER

I, ________________, certify that the foregoing information is correct to the best of my knowledge, and agree to the following:

(Please print name of subscriber)

1 . . . I will inform Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. of any changes affecting the above dependent's status.

2 . . . I agree to refund to Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. any monies paid by Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. on the above dependent should that dependent at any time not qualify under the above guidelines and during that period of qualification Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. paid monies for the above dependent based on the certification, and

3 . . . I authorize Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. to verify, directly or indirectly, or through its authorized agents, any of the foregoing information.

__________ X ________________

Date Subscriber's Signature

OFFICE USE ONLY		
UW Int.	Approved	Not Aprvd.

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

24XX0205 R05/04

Thank you!