MUST
MONTANA UNIFIED SCHOOL TRUST

ATTENDING PHYSICIAN'S STATEMENT

For Mentally or Physically Impaired Dependent Child

1 To be completed by Employee/Participant

Group Name:	Employee First Name:	MI:	Employee Last Name:

Dependent Child First Name:	MI:	Dependent Child Last Name:	Date of Birth:

Please indicate the nature of 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 answered "no" to these questions, but you are required to provide coverage due to court order or divorce decree for a child not in your custody or not wholly dependent on you for support, please indicate so 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 this child has other medical coverage, please indicate below:

- ☐ Other Group Health Insurance (indicate plan name and plan ID number):
- ☐ CHAMPUS/Tricare (coverage through the U.S. armed forces)
- ☐ Worker's Compensation (give name of carrier):
- ☐ Medicaid
- ☐ Medicare
- ☐ Other - Please describe:

Please indicate the child's level of education, if applicable:		**Is the child currently attending school?**	
☐ Not Applicable	☐ College	☐ **YES** (if YES, which type?)	☐ **NO**
☐ Elementary	☐ Vocational/Occupational Training	☐ High School	☐ Vocational/Occupational Training
☐ Junior High	☐ Special Education	☐ College	☐ Special Education
☐ High School	☐ Other - Describe:_____		

Authorization to Obtain and Disclose Information

I authorize any physician, medical practitioner, hospital, clinic, pharmacy, or any other healthcare 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 Blue Cross and Blue Shield of Montana, the third party administrator of Montana Unified School Trust (MUST). I understand that any information provided will be kept confidential and will not be released to any person or organization other than MUST. I understand that any information provided will be kept confidential and will not be released to any person or organization other than the MUST's stop-loss carrier, MUST employees who require such information to complete work assigned to them, to any authorized and properly identified governmental regulation 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 for 24 months from the date of execution, unless I affirmatively revoke the authorization in writing. I understand that I have a right to receive a copy of this authorization upon request.

_____
EMPLOYEE / PARTICIPANT SIGNATURE **DATE**

FOR MUST USE ONLY: Date Entered ____/____/____

NOTES: _____Q/A INIT_____

ATTENDING PHYSICIAN'S STATEMENT

For Mentally or Physically Impaired Dependent Child

2 To be completed by Healthcare Provider

Notice to Provider: Montana Unified School Trust (MUST) 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. Montana state law provides that a healthcare provider may disclose healthcare information about a patient to a third-party healthcare payer, in this case Blue Cross and Blue Shield of Montana, who requires healthcare information provided that the third-party payer not use or disclose the healthcare information for any other purpose and takes appropriate steps to protect the information. Please be assured that 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 "need to know" basis to complete the work assigned to them. MUST does not disclose confidential medical information without the express written permission of the party controlling the information or to a legally authorized and proper identified governmental regulator authority unless such disclosure is (a) necessary and appropriate to complete work assigned, (b) specifically authorized in writing by the controlling part, or (c) compelled by applicable law. Please attach any supporting documentation that you believe will assist in determining eligibility.

Nature of Impairment / Disability and Diagnosis:

History **Is the impairment due to:**	**Details of Impairment** **Is the impairment:**	**Is the patient:**
☐ Accident	☐ Mental	☐ Ambulatory
☐ Illness	☐ Physical	☐ Bed Confined
☐ Complications of Birth / Congenital	☐ Developmental	☐ House Confined
☐ Other: _____	☐ Other:_____	☐ 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
Has patient been hospital confined?	☐ **YES**	☐ **NO**		

If YES, give name and address of hospital with dates of confinement:

Is patient capable of attending school or receiving vocational / occupational training? ☐ **YES** ☐ **NO** ☐ **YES, but with special needs**

Date of treatment (including name and date(s) of any surgery, medications prescribed, therapy, etc.)

Date of first visit (MM/DD/YYYY):

Date of most recent visit: (MM/DD/YYYY):

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 NO, please indicate reason(s):

Progress and Prognosis

Has patient:	☐ Recovered	☐ Improved	☐ Stayed the same	☐ Declined
Is the patient expected to:	☐ Recover	☐ Improve	☐ Stay the same	☐ Decline

I affirm the above information is correct. I authorize any hospital in which confinement took place to furnish Blue Cross and Blue Shield of Montana 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:_____ **Degree:**_____ **Phone:**_____

Street Address:_____ **City:**_____ **State:**____ **ZIP:**_____

Signature of Attending Physician:_____ **Date:**_____