

**DEPENDENT CONTINUED COVERAGE –  
PHYSICAL OR MENTAL DISABILITY  
ATTENDING PHYSICIAN OR PSYCHOLOGIST QUESTIONNAIRE**

**Please note this form must be completed and signed by the Member's attending Physician or Psychologist.**

SHBP Plan Member Name \_\_\_\_\_

Member SSN \_\_\_\_\_

Patient/Dependent Name \_\_\_\_\_

Relationship \_\_\_\_\_

**Complete questions A through D for all patients:**

- A. Detail past medical history and current medical conditions which impact or contribute to the impairment or disability. Provide a history of hospitalizations. List all medicines currently taken.
- B. Prognosis: Describe the level of impairment or disability. Is the impairment or disability partial or total? Is the impairment or disability temporary or permanent?
- C. Capability: Is the patient capable of part-time or full-time employment? Has the patient applied for or received Social Security disability benefits? Describe any restrictions.
- D. Activities of Daily Functioning: Describe a “typical day” for the patient including all activities such as: housework, cooking, shopping, watching TV, etc. Provide a copy of a functional capacity evaluation if available.

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Physician or Psychologist Name \_\_\_\_\_

Provider Address \_\_\_\_\_

Provider Phone Number \_\_\_\_\_

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**If the patient is mentally disabled, please complete sections E through H and include specific examples of behavior relative to the following items which are necessary for objective documentation. Please provide a copy of the current psychological evaluation including IQ scores.**

E. Interests: Comment on any hobbies, sports, or social activities, etc.

F. Ability to Relate to Others: Comment on frequency of trips outside the home, reaction to friends, family, crowds, & conversational ability.

G. Deterioration of Personal Habits: Comment on grooming, apparel, & ability to care for personal needs independently.

H. Mental Status Evaluation and date of evaluation \_\_\_\_\_

**Please provide current mental status evaluation information & give behavioral examples as applicable.**

1. Appearance & behavior:
  
2. Stream of conversation & psychomotor activity:
  
3. Thought content:
  
4. Perceptual abnormalities:
  
5. Affect:

6. Concentration:

7. Cognitive function:

8. Additional Comments:

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Physician or Psychologist Name \_\_\_\_\_

Provider Address \_\_\_\_\_

Provider Phone Number \_\_\_\_\_