SHBP
State Health Benefit Plan
A Division of the Georgia Department of Community Health

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.

MEMBER INFORMATION (tell us more about the person requesting the appeal; Note: only Members can request continued coverage for a Dependent due to Disability)

First Name:_____ Middle Name:_____

Last Name:_____ SSN or Plan ID #:_____

Street Address: _____

City:_____State:____ Zip Code:_____

Daytime phone number:_____

DEPENDENT INFORMATION (tell us more about the Dependent for whom you are requesting continued coverage)

First Name:_____ Middle Name:_____

Last Name:_____ SSN: _____

Street Address: _____

City:_____State:____ Zip Code:_____

Daytime phone number:_____ Relationship to Member:_____

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_____

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_____

Please send this originally executed form to:

State Health Benefit Plan
Attention: Eligibility & Benefits Administration
Post Office Box 1990
Atlanta, GA 30301

-OR-

shbp.eligibility@dch.ga.gov

-OR-

1-866-828-4796 Fax