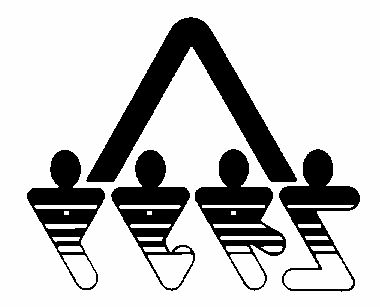
# 58798-{stdMbrPERSLinkID}

# PHYSICIAN FORM FOR HANDICAPPED DEPENDENT



NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58798 (Rev. 01-2014)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| DATE | SUBSCRIBER’S NAME (EMPLOYEE) {stdMbrFullNameLFM} | | | DEPENDENT’S NAME | | | |
| NDPERS Member Id {stdMbrPERSLinkID} | | Last Four Digits of Social Security Number  {stdMbrLastFourDigitsOfSSN} | | | | Date of Birth {stdMbrDateOfBirth} | |
| SUBSCRIBER’S ADDRESS:  Street: | | | | | | | |
| City: | | State : | | | Zip Code: | | |
| NAME OF INSURANCE PLAN: | | | INSURANCE PLAN CODE: | | | | ID NUMBER: |
| GROUP NAME | | | NDPERS Organization ID {stdCurrentEmployerOrgCodeID} | | | | |

Please respond to the questions below in as complete a manner as possible. This information will assist the insurance provider in determining this patient’s eligibility for continued insurance coverage as a handicapped dependent.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***To Identify the Treating Physician:***  Physician Name: | | | | | |
| Specialty: | | | | | |
| License Number: | | | | | |
| Address: | | | | | |
| Telephone Number: | | | Fax Number: | | |
| Diagnosis(es) (ICD-9): |  |  | |  |  |
| 1. How long have you treated this patient and when did you last see him/her? | | | | | |
|  | | | | | |
| 2. What is the degree of physical/mental impairment? | | | | | |
|  | | | | | |
|  | | | | | |
| 3. In your professional opinion, is this patient continuously incapable of self-sustaining employment due to a physical or mental handicap?  No  Yes | | | | | |
| If yes, please explain. | | | | | |



PHYSICIAN FORM FOR HANDICAPPED DEPENDENT

# SFN 58798 (Rev. 01-2014) Page 2

|  |  |
| --- | --- |
| SUBSCRIBER’S NAME (EMPLOYEE) {stdMbrFullNameLFM} | NDPERS Member Id {stdMbrPERSLinkID} |

|  |
| --- |
| 4. How long has this patient been incapable of self-sustaining employment? (Please answer this question based upon your understanding of the patient’s medical history.) |
| 5. When, in your professional opinion, might this patient be capable of self-sustaining employment? |
|  |
|  |
| 6. Is the individual trainable/educable? |
|  |
|  |
|  |
| Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_ |
| Physician Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please mail this form to: To your health care provider listed on the back of your ID card.