Disabled Dependent Certification

Sutter Health Plan

This form is for Sutter Health Plan subscribers to request disabled dependent certification. Subscribers may request certification for disabled dependents over the age of 26 who would otherwise lose Sutter Health Plan eligibility. The dependent must be dependent on the subscriber or the subscriber's spouse/domestic partner for support and maintenance. The dependent also must be incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition incurred before age 26. The subscriber and the dependent's doctor must complete and sign this form.

Mail, fax or email your completed form to:

EMAIL
shpserviceteam@sutterhealth.org

FAX
916-736-5426

MAIL
Sutter Health Plan
P.O. Box 160345
Sacramento, CA 95816

Section A – Subscriber Information

Group Name | **Group #** | **Subscriber ID #**

Last Name | **First Name** | **MI**

Address | **City** | **State** | **ZIP**

Phone | **Email**

Section B – Dependent Information

Last Name | **First Name** | **MI**

Date of Birth | **Member ID #** | **Social Security #**

Does dependent receive 50% or more support and maintenance from subscriber or subscriber's spouse/domestic partner? ☐ **Yes** ☐ **No**

Did disability exist prior to age 26? ☐ **Yes** ☐ **No**

Sutter Health Plan

Section C – Subscriber Signature

By signing this form, I declare that the information I have provided is true and complete. I understand that if benefit payments are incorrectly or improperly made, I shall be fully responsible to Sutter Health Plan for repayment of all costs, fees and expenses related to such payments. Further, I understand that to the extent permitted by law, Sutter Health Plan may deny benefits and retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility.

Subscriber Signature **Date**

Section D – Disability Diagnosis –To be completed by dependent's attending physician

Describe disability diagnosis

Disability diagnosis ICD-10 code(s)

Is disability likely to improve? ☐ **Yes** ☐ **No**

If yes, expected date

Is the dependent capable of self-sustaining employment? ☐ **Yes** ☐ **No**

If yes, expected date

Physician comments (Attach additional documentation if needed.)

Physician Signature **Date**

Physician Name

Address **City** **State** **ZIP**