Disability Eligibility Determination

Instructions for Completing this Form

Complete this form to continue coverage if you or a member on your plan is disabled. The plan Subscriber should complete **Section 1** of this form. The disabled member's Primary Care Physician should complete **Section 2** of this form.

The completed form must be returned to MVP Health Care® within 30 days to ensure there is no lapse in coverage for the disabled member. Return the form and any supplemental information *(see documentation required below)* to:

ATTN: ENROLLMENT & ELIGIBILITY
MVP HEALTH CARE
PO BOX 2207
SCHENECTADY NY 12301-2207

Questions? Call the MVP Customer Care Center at the phone number on the back of your MVP Member ID card.

Section 1: Subscriber and Disabled Member Information *(to be completed by the MVP Subscriber)*

Date *(MM/DD/YYYY)*	**Subscriber** Name	**MVP Subscriber ID No.**

Subscriber Street Address	City	State	Zip Code

Disabled Member Name	**Disabled Member** Date of Birth	**Disabled Member** MVP Subscriber ID No.

Does the disabled member receive Social Security Income (SSI) for this disability? ☐ **Yes** ☐ **No**

Does the disabled member have other insurance coverage for this disability, such as Medicare or Medicaid? ☐ **Yes** ☐ **No**

Is or was the disabled member employed? ☐ **Yes** How many hours per week? ________ ☐ **No**

Section 2: Member's Disability Information *(to be completed by the Primary Care Physician)*

Disabled Member's Diagnosis	Disabled Member's Occupation	
	Date of Disability	Age at Which Member Became Disabled

Do you consider this a permanent disability ☐ **Yes** ☐ **No** *Expected length of disability?* ________

Reason for the disability *(select all that apply)*

☐ **Mental Illness** ☐ **Intellectual and Developmental Disability** ☐ **Physical handicap** ☐ **Pregnancy** ☐ **Other**

Describe, or provide documentation, of the member's current cognitive functioning level *(If applicable)*.

Describe, or provide documentation, of the member's physical handicap and the extent of physical functioning.
For example, is the member ambulatory? What is the level of upper and lower body functioning?

Please include the following documentation when submitting this form:

- A complete history including a current physical, outlining the member's disability
- A current cognitive functioning level and current vocational assessment
- Any appropriate, current supporting documentation from specialty care physicians

Physician's Signature *Date*