



Disability Eligibility Determination Form

TO BE COMPLETED BY PRIMARY CARE PHYSICIAN

Patient Name: _____

Date of Birth: _____ Member Number: _____

1. Date at which patient became disabled. _____

2. Do you consider this a permanent disability? Yes No
If no, please indicate the expected length of the disability. _____

3. Diagnosis _____

4. At what age was this disability manifested? _____

5. Is this disability the result of a (please check all that apply):
 Mental illness Developmental disability
 Mental retardation Physical handicap
 Other, (please explain) _____

6. Please describe (or provide documentation) of the patient's current cognitive functioning level (if applicable).

7. Patient's IQ _____ Testing method utilized _____

8. Please describe (or provide documentation) of the patient's education and level of training (if applicable):

9. Please describe the patient's work history: _____

10. Please describe (or provide documentation) of the patient's physical handicap and the extent of physical functioning (i.e. is the patient ambulatory, what is the level of upper and lower body functioning, etc.).

Please attach the following information:

- A complete history including a current physical outlining the patient's disability
- A current cognitive functioning level and current vocational assessment.
- Current supporting documentation from specialty care physicians that is appropriate.

Physician's Signature _____ Date _____