Disabled Dependent Certification

Sutter Health Plus

This form is for Sutter Health Plus subscribers to request disabled dependent certification. Subscribers may request certification for disabled dependents over the age of 26 who would otherwise lose Sutter Health Plus 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
shpenrollmentmailbox@sutterhealth.org

FAX
916-736-5426

MAIL
Sutter Health Plus
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 Plus
Your 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 Plus for repayment of all costs, fees and expenses related to such payments. Further, I understand that to the extent permitted by law, Sutter Health Plus 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**