Proof of Incapacity of a Dependent | Physician's Form

Policyholder name		Policyholder ID number	
Address	**City**	**State**	**ZIP**

The insurer covers dependent children that have reached the maximum dependent age and are physically or mentally incapacitated. In order to make a determination, the following information must be completed. **Please attach any supporting documentation.**

Dependent Name	Current age	Height	Weight

Mental incapacity ☐ Yes ☐ No	If Yes, add IQ score	Physical incapacity ☐ Yes ☐ No	Age at onset of condition/disability

Describe incapacity or reason incapable of self care/self support

Describe acute medical conditions

Describe chronic medical conditions

Future health concerns or considerations

Medications, dosage, reason for medications

Other important facts

A copy of any pertinent medical information may be attached.

I have examined the dependent named above, and the degree of his/her disability or incapacity is of such a nature that he/she is incapable of self care/self support.

Physician name	Specialty
Physician signature	**Date**

Please return this signed form to:
ATTN: Corporate Medical Director Division
P.O. Box 2181
Little Rock, AR 72203-9974

Fax: 501-399-3967
Email: CMDIncapacitatedDepReq@arkbluecross.com

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