Your Future — Our Focus

CHICAGO REGIONAL COUNCIL OF CARPENTERS HEALTH-WELFARE FUND
12 East Erie Street
Chicago, IL 60611
(312) 787-9455 – Option 3

Attending Physician's Statement for Continuation of Coverage for a Physically or Mentally Disabled Dependent

Instructions: **Print Clearly in Ink**. The Disabled Dependent's physician must complete this form in full and sign it. The Participant must return this form, along with the Participant's Statement to the Fund Office in the enclosed envelope. **Failure to complete this form in full** will result in the form being returned to the participant and a delay of claim payments for the disabled dependent.

Participant's Name:	**Participant's UID#** (UID# is on BCBS I.D. Card)
Dependent's Name:	**Dependent's Date of Birth**:

Nature and degree of disabling condition. (Please furnish full diagnosis and CPT Code. Be as detailed as possible.)

Date you first treated the Patient:	**Frequency of visits:**	**When did you last treat the Patient?**
_____/_____/_____ Month Day Year	☐ Weekly ☐ Monthly ☐ Other _____ Please specify	_____/_____/_____ Month Day Year

What was the nature of the last treatment?

Extent of Disability

(a) Is the patient able to manage an independent existence? ☐ Yes ☐ No

(b) What are his/her limitations?

Mental: _____

_____

Physical: _____

_____

(c) Has such disability existed continuously since before the patient attained age 19? ☐ Yes ☐ No

(d) What type of work can this individual perform? _____

_____

Remarks:

Signature of M.D.: _____ **Dated**: _____

Print Name: _____ **Phone Number**: _____

Physician's Tax ID No.: _____ **Physician's License No.:** _____

Street Address: _____

City, State & Zip: _____

PHYSINCAP

10/2015

Note: Any fee for the completion of this form is the responsibility of the Participant