

Anthem Blue Cross and Blue Shield Request to Continue Dependent Coverage



Form completion tips

You can use this form if one of your dependents will be too old to stay on your plan, but you want to request to keep them covered. Your dependent may be able to stay on your plan if they are impaired due to a physical or mental illness, injury, or condition. Please refer to your plan documents for complete information about requirements for a dependent to remain covered on your plan.

If you have questions or need help, please call us at the Member Services number on your ID card.

Please fill in all sections on both pages completely. Your request cannot be processed if any information is missing.

If your Anthem Individual health plan was effective on or after January 1, 2014, please mail or fax the completed form to:

CO CT GA IN KY ME MO NH NV OH WI

Anthem Blue Cross and Blue Shield

P.O. Box 659960

San Antonio, TX 78265-9146

Fax: 877-628-4593

If your Anthem Individual health plan was effective before January 1, 2014, please mail or fax the completed form to:

CO CT ME NH NV

Anthem Blue Cross and Blue Shield

P.O. Box 9051

Oxnard, CA 93031

Fax: 877-628-4593

GA IN KY MO OH WI

Anthem Blue Cross and Blue Shield

P.O. Box 659806

San Antonio, TX 78265-9106

Fax: 877-628-4593

If your Anthem plan is through your employer's group plan, please mail the completed form to the address for your state (the state where your employer is headquartered). For complete information about requirements for a dependent to remain covered on your employer-sponsored health plan, please refer to your plan documents, contact your employer, or call us at the Member services number on your ID card.

CO NV (Large Group)

Anthem Blue Cross and Blue Shield

P.O. Box 629

Woodland Hills, CA 91365

CO CT GA IN KY ME MO NH NV OH WI (National Accounts)

Anthem Blue Cross and Blue Shield

6087 Technology Pkwy

Mail Point GA082W-0003

Midland, GA 31820

CT IN KY ME MO NH OH WI (Small Group)

Anthem Blue Cross and Blue Shield

P.O. Box 659960

San Antonio, TX 78265-9146

CT IN KY ME MO NH OH WI (Large Group)

Anthem Blue Cross and Blue Shield

P.O. Box 659210

San Antonio, TX 78265

GA (Small Group and Large Group)

Anthem Blue Cross and Blue Shield

P.O. Box 4445

Atlanta, GA 30302

Anthem Blue Cross and Blue Shield Request to Continue Dependent Coverage



Your request cannot be processed if any information is missing.

Section 1: Subscriber information

Last name		First name		M.I.	Member ID no.	
Street address			City		State	ZIP code
Phone no.	Employer name			Group no.		

Section 2: Dependent information

Last name		First name		M.I.	Date of birth (MMDDYYYY)	
Social Security no.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single		Relationship to subscriber		
Type of impairment or injury					Date of impairment or injury	
Does the subscriber claim the dependent for income tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Does the dependent live with the subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If no to either question, please explain: _____						

Section 3: Additional insurance policies for this dependent

Does the dependent have another health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Will your Anthem policy replace their other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes to either question, complete the following.			
Other plan's policyholder name		Date of birth (MMDDYYYY)	Policy no.
Health insurance company name		Other plan phone no.	Other plan group no.
RX Bin	RX PCN	Date coverage started	Date coverage ended
How did they get these benefits? <input type="checkbox"/> Through employer <input type="checkbox"/> As individual <input type="checkbox"/> Another way – describe: _____			
Is the dependent currently receiving Social Security benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what was the effective date? _____		If no, have benefits been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medicare – Answer these questions if their other health plan is Medicare.

Name of Medicare cardholder	Medicare claim ID/no.	Effective dates for each part	Medicare entitlement reason
		A: _____ B: _____ C: _____	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD*

*If ESRD (kidney or renal failure) is the primary reason for Medicare, provide the date of first dialysis treatment: _____
and transplant date if applicable: _____

Signature required

I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.	
Signature of subscriber X	Date (MMDDYYYY)

Section 4: Diagnosis/Prognosis – Must be completed and certified by a physician.

Diagnosis		ICD-10 code(s)	
Describe the dependent's limitations in performing daily activities and ability to manage their affairs			
In your opinion, is the above named dependent currently incapable of self-sustained employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In your opinion, will the dependent ever be capable of self-sustained employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," provide estimated date of return to full functionality: <div></div> (MMDDYYYY)			
Physician name		Physician signature X	
		Date (MMDDYYYY) <div></div>	
Physician street address		City	State ZIP code

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