



**North Carolina  
State Health Plan**  
FOR TEACHERS AND STATE EMPLOYEES  
A Division of the Department of State Treasurer

**Coverage Request for a Dependent Child with a Disability**

Please Return Completed Form to:  
North Carolina State Health Plan Attn: Customer Experience  
3200 Atlantic Avenue Raleigh, NC 27604

**SECTION A - TO BE COMPLETED BY MEMBER**

NAME OF SUBSCRIBER	ADDRESS OF MEMBER	MEMBER ID NUMBER
MEMBER EMAIL ADDRESS		
NAME OF DEPENDENT CHILD	SOCIAL SECURITY NUMBER OF DEPENDENT	DEPENDENT CHILD DATE OF BIRTH
IS THE DEPENDENT CHILD ELIGIBLE FOR THEIR OWN EMPLOYER SPONSORED COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IS DEPENDENT CHILD ELIGIBLE FOR MEDICARE? <input type="checkbox"/> YES → IF YES, GIVE EFFECTIVE DATES: PART A EFFECTIVE DATE: PART B EFFECTIVE DATE: <input type="checkbox"/> NO		

Pursuant to N.C.G.S. § 135-48.44(a)(6), Plan members who are found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact regarding eligibility, enrollment, or in a claim for reimbursement by the Plan shall have their coverage terminated, be ineligible for Plan coverage for five years, and make a full and complete restitution to the Plan for all fraudulent claim amounts. Pursuant to the North Carolina False Claims Act, N.C.G.S. § 1-607 et seq., it is unlawful for any person to (1) knowingly present or cause to be presented a false or fraudulent claim to the Plan or (2) knowingly make, use, or causes to be made or used a false record or statement material to a false or fraudulent claim. I attest that I have read and understand the above and the information and materials I have included in this form are true and accurate.

ATTESTATION AND SIGNATURE OF MEMBER:

DATE SIGNED:

**SECTION B - TO BE COMPLETED BY CERTIFYING PHYSICIAN**

DATE YOU LAST SAW THE PATIENT:	IS DISABILITY CONGENITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO →	IF NO, DATE OF DISABILITY OR DATE OF ONSET OF DISABILITY (REQUIRED):
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DIAGNOSIS OF CONDITION(S) CAUSING DISABILITY STATUS:

IS THIS PATIENT INCAPABLE OF SELF-SUSTAINING EMPLOYMENT FOR A PERIOD OF ONE YEAR OR LONGER?  YES → IF YES, HOW LONG?  LESS THAN 1 YEAR  2-5 YEARS  PERMANENT  
 NO

PLEASE PROVIDE DETAILS EXPLAINING THE DEGREE OF DISABILITY AND /OR FUNCTIONAL LEVEL, TREATMENT AND PROGNOSIS:

OFFICE MANAGER CONTACT:

NPI OF CERTIFYING PHYSICIAN: ADDRESS:

Pursuant to the North Carolina False Claims Act, N.C.G.S. § 1-607 et seq., it is unlawful for any person to (1) knowingly present or cause to be presented a false or fraudulent claim to the Plan or (2) knowingly make, use, or causes to be made or used a false record or statement material to a false or fraudulent claim. I attest that I have read and understand the above and the information and materials I have included in this form are true and accurate.

ATTESTATION AND SIGNATURE OF CERTIFYING PHYSICIAN:

DATE SIGNED:

**SECTION C - FOR INTERNAL OFFICE USE ONLY**

DECISION		REVIEWED BY:
APPROVED	DENIED	
DURATION:	COVERAGE ENDS:	DECISION DATE:
COVERAGE CONTINUES:		

Completed forms should be mailed to:

North Carolina State Health Plan Attn: Customer Experience 3200 Atlantic Avenue Raleigh, NC 27604 or faxed to: 919-855-5817