CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559
www.carefirst.com

Date: _____

Dear Parent/Guardian:

Thank you for your interest in health insurance with CareFirst BlueCross Blue Shield. Upon review of your records, we have found that additional information is needed to determine if the child listed below may enroll as a disabled dependent in the health plan you applied for or remain enrolled after reaching age nineteen.

Subscriber Name			**Membership Number**
Street	**City**	**State**	**Zip Code**
Child Name:		**Child Date of Birth:**	

Please have the attending physician provide the information requested in the space below and send it to: CareFirst BlueCross BlueShield, National Accounts Enrollment and Billing, 10455 Mill Run Circle, Mail Stop OM2-250, Owings Mills, MD 21117-5559.

I hereby authorize the following information to be released by attending physician.

_____
Signature of Parent/Guardian Date

Physician's Name			
Street	**City**	**State**	**Zip Code**
Diagnosis:		**Date of Inception:**	
Prognosis:			

Does the condition preclude any substantial gainful work? ☐ **No** ☐ **Yes**

Is the child in an institution? ☐ **No** ☐ **Yes** **Admission date:** _____

Institution name: _____

Please attach copies of supporting documentation regarding the disability.

Physician's Signature
_____
Date

If you need additional information, please call 410-998-6980.

Sincerely,

National Accounts Enrollment and Billing