Health Care Authority
Public Employees Benefits Board

PEBB Certification of a Child with a Disability

A Guidelines to certify a child with a disability

Your child age 26 or older may be eligible for enrollment in your Public Employees Benefits Board (PEBB) health plan coverage if:

- Your child has a developmental or physical disability that occurred before age 26, or
- They are incapable of self-sustaining employment and chiefly dependent upon you for support and ongoing care.

Follow the instructions below and on the next page to certify or recertify a child with a disability. The form begins on page 3.

⚠ For certification approval, you must provide thorough and complete information, meet program eligibility requirements, and submit all required documents within the timelines described below. Approval of certification is based on your child's clinical condition.

As used here, children are defined as described in WAC 182-12-260(3), which includes children with whom you have a parent-child relationship as defined in RCW 26.26A.100 and children with disabilities age 26 or older.

B First-time certification instructions

First-time certification is required for:

- A currently enrolled child with a disability when they turn age 26, or
- A newly eligible child with a disability who is age 26 or older.

1. **Enroll or make changes through Benefits 24/7 at benefits247.hca.wa.gov or complete and submit the appropriate PEBB election/change form.**
2. **Send this certification form to the medical plan you chose to enroll in. If you are enrolling in a UnitedHealthcare plan or are enrolling the child in dental and/or vision only, send this form to the PEBB Program.**

Forms must be received within the timelines below:

Newly eligible employees
No later than 31 days after becoming eligible for PEBB Program benefits.

New retirees
No later than 60 days after your own employer-paid, COBRA or continuation coverage ends. For elected or full-time appointed officials, no later than 60 days after you leave public office.

PEBB Continuation Coverage (Employer Group Ended Participation) subscribers
No later than 60 days after your employer group ended participation.

Currently enrolled subscribers
No later than the last day of the PEBB Program's annual open enrollment, or 60 days after a qualifying special open enrollment event.

Currently enrolled child turning age 26
No later than 60 days after the child with a disability turns age 26.

For more enrollment events, see PEBB Program Administrative Policy 36-1 at **hca.wa.gov/pebb-rules**.

⚠ If the forms are not received within the timelines listed above, the PEBB Program can deny coverage for your child.

C Recertification instructions

If your child with a disability is currently enrolled and it is time to recertify their eligibility:
Send this certification form to the medical plan you are enrolled in. Exception: If you are enrolled in a UnitedHealthcare plan or the child is enrolled in dental and/or vision only, send this form to the PEBB Program. Your form must be received **by the due date** listed in the recertification request letter mailed to you.

D To return this form

For United Healthcare plans or dental coverage only, send this form to the PEBB Program:

PEBB Program
Health Care Authority
PO Box 42684
Olympia, WA 98504

Fax: 360-725-0771

For all other medical coverage, send this form to your medical plan at the address below.

Kaiser Foundation Health Plan of the Northwest

Attn: Membership Administration
500 NE Multnomah Street, Suite 100
Portland, OR 97232
Fax: 855-524-5257
Phone: 503-813-4224
Email: **nw.membership.administration@kp.org**

Kaiser Foundation Health Plan of Washington

Clinical Review Unit
PO Box 34589
Seattle, WA 98124
Fax: 1-800-377-8853
Phone: 1-800-289-1363

Uniform Medical Plan

Regence BlueShield
PO Box 1106
Lewiston, ID 83501
Fax: 1-855-639-3940
Phone: 1-888-849-3681

⚠ If you want to cover your child with a disability on your medical plan and you send this form to the PEBB Program in error, your coverage could be delayed or denied.

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format or language, please contact the following. **Employees:** Contact your payroll or benefits office. **Retirees and PEBB Continuation Coverage subscribers:** Call us at 1-800-200-1004 (TRS: 711).

HCA's Privacy Notice: HCA will keep your information private except as allowed by law. To see our Privacy Notice, visit the HCA website at **hca.wa.gov**.

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Type or print clearly in dark ink and use all capital letters in the spaces provided. Example: J O H N

Complete Sections 1 through 3. Your child's provider must complete Sections 4 through 6 as required. Inaccurate, incomplete, or illegible information may delay coverage.

1 Subscriber information

Social Security number

Date of birth (mm/dd/yyyy)

Last name

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

Country

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

2 Child with a disability information

Social Security number

Date of birth (mm/dd/yyyy)

Last name

First name

Middle initial

Suffix

Relationship to subscriber

☐ Child ☐ Stepchild ☐ Extended dependent

Subscriber's last name

Social Security number

What kind of certification is this?

- Newly eligible enrollment
- Enrollment at age 26
- Annual open enrollment change
- Recertification
- Special open enrollmen t change

What coverage is this child enrolled or enrolling in? (Check all that apply.)

- Medical
- Dental
- Vision

Note: Retirees and their dependents must enroll in medical to enroll in dental and/or vision. Retirees enrolled in Medicare Part A and Part B receive their vision coverage through Medicare and are not eligible for stand-alone vision.

Does this child have Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)?

- Yes
- No

If **yes**, submit a copy of the most recent SSI or SSDI Notice of Award letter with this form. The letter must state that your child has been awarded SSI or SSDI based on being disabled. Also **check "yes" at the top of Section 5** to let your child's provider know they do not need to complete that section.

⚠ **Employment information for your child is required to verify they are incapable of self-sustaining employment and chiefly dependent upon you for support and ongoing care. If left blank, certification may be denied.**

Has this child ever been employed?

- Yes
- No

If yes, list all the employer names and dates of employment:

Is this child currently employed?

- Yes
- No

If yes, list the current employer name, dates of employment, and hours worked (per week or per month):

3 Subscriber's signature

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the PEBB Program's required timelines, I must repay any claims paid by my health plan(s) or premiums paid on my child's behalf to the extent permitted by federal and state laws. My child may also lose PEBB health plan coverage as of the last day of the month they were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not pay premiums and applicable premium surcharges when due. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of benefits.

I understand that the PEBB Program will verify eligibility for my dependent and may ask for this verification at any time. The PEBB Program will verify the disability and dependency for a child with a disability periodically, but not more than annually after the two-year period following the dependent's 26th birthday. My health plan may provide input; however, the PEBB Program performs the certification of eligibility.

This form replaces all previous *Certification of a Child with a Disability* forms I have submitted for PEBB Program benefits. I understand I must notify the PEBB Program in writing no later than 60 days after the last day of the month my child is no longer eligible as a child with a disability.

Subscriber's signature

Date (mm/dd/yyyy)

Subscriber's last name

Social Security number

4 Provider information

To be completed by the child's health care provider.

Provider last name

First name

Middle initial

Suffix

National Provider Identifier (NPI) number

Mailing address

Mailing address line 2

City

State

ZIP/Postal code

County

Is this child chiefly dependent on the subscriber for support and ongoing care? Yes No

Has this child's disability existed continuously since before age 26? Yes No

5 Diagnosis and prognosis

Note to subscriber: Answer the question below to show whether the child's provider must complete this section.

Are you submitting a copy of the child's SSI or SSDI award letter with this form? Yes No

If **no**, the child's provider must complete this section. Approval of the child's disability certification for health plan coverage is based on the level of detail provided about their diagnosis, prognosis, and necessity for support and ongoing care.

If **yes**, the provider does not have to complete this section. **The provider must complete Section 6.**

Nature and level of disability (including diagnosis with ICD Code)

Please give as much detail as possible about the child's diagnosis and present condition, current treatments and whether these have been maximized/optimized, as well as the stability of their condition. Be specific about the way in which the condition renders them incapable of self-support. Attach additional supporting information as necessary.

Subscriber's last name

Social Security number

Prognosis

Please estimate the expected duration of the disability.

6 Provider's signature

I certify that, to the best of my knowledge and belief, the information I have provided is true and correct.

Provider's signature

Date (mm/dd/yyyy)