SEBB Certification of a Child with a Disability

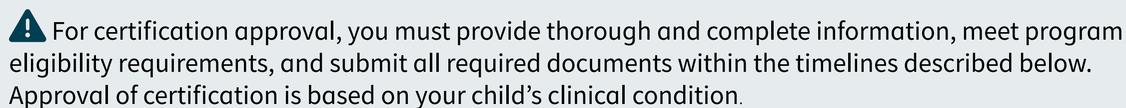
Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

A Guidelines to certify a child with a disability

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

- Your child has a developmental or physical disability that occurred before age 26, and
- 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.

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 on the HCA website at **benefits247.hca.wa.gov** or complete and submit the appropriate SEBB election or change form as instructed on the form.
2. Send this certification form to the medical plan you chose to enroll in. If you are enrolling the child in dental and/or vision only, send this form to the SEBB Program. Address information is on the next page.

Forms must be received within the timelines described below:
Newly eligible employees: No later than 31 days after becoming eligible for SEBB Program benefits.
School Board Members: No later than 60 days from the beginning of their elected or appointed term.
Currently enrolled subscribers: No later than the last day of the SEBB 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 SEBB Program Administrative Policy 36-1 at **hca.wa.gov/sebb-rules**.

If the forms are not received within the timelines listed above, the SEBB 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 the child is enrolled in dental and/or vision only, send this form to the SEBB Program. Your form must be received **by the due date** listed in the recertification request letter mailed to you.

* As used here, children are defined as described in WAC 182-31-140(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 and older.

D To return this form

For dental and/or vision coverage only, send this form to the SEBB Program:

SEBB Program
Health Care Authority
PO Box 42720
Olympia, WA 98504-2720

Fax: 360-725-0771

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

Kaiser Foundation Health Plan of the Northwest

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 and Kaiser Foundation Health Plan of Washington Options, Inc.

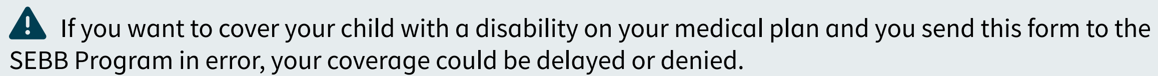
Kaiser Foundation Health Plan of Washington
Clinical Review Unit
PO Box 34589
Seattle, WA 98124
Fax: 1-800-377-8853
Phone: 1-800-289-1363

Premera Blue Cross

Premera Blue Cross
Membership & Billing, MS 137
PO Box 327
Seattle, WA 98111
Fax: 1-425-918-6335
Phone: 1-800-807-7310

Uniform Medical Plan

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



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. SEBB Continuation Coverage members: 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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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.

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

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)

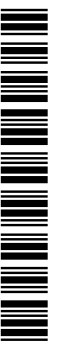
Mailing address line 2

City

State

ZIP/Postal code

Country



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

SEBB Certification of a Child with a Disability

Subscriber's last name

Social Security number

What kind of certification is this?

Newly eligible enrollment

Enrollment at age 26

Annual openenrollment change

Recertification

Special open enrollment change

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

Medical

Dental

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 that 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/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 SEBB 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 SEBB Program benefits as of the last day of the month they were eligible. To the extent permitted by law, the SEBB 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.

The SEBB Program will verify eligibility for my dependent. I understand that the SEBB Program may ask for this verification at any time. However, the SEBB 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 SEBB Program performs the certification of eligibility.

This form replaces all previous *Certification of a Child with a Disability* forms I have submitted for SEBB Program benefits. I understand I must notify the SEBB 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 Country

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

Subscriber's last name | Social Security number

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. Please be specific about the way in which the condition renders them incapable of self-support. Attach additional supporting information as necessary.

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)