2022 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

After turning age 26, your child* may be eligible for enrollment in your School Employees Benefits Board (SEBB) health plan coverage if:

- Your child's developmental or physical disability occurred before age 26, and
- They are incapable of self-sustaining employment and chiefly dependent upon you for support and on-going 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 on time. Approval of certification status 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.

Employees

1. Enroll or make changes through SEBB My Account on the HCA website at **myaccount.hca.wa.gov** or complete and submit the appropriate SEBB election or change form to your payroll or benefits office.
2. Send this certification form to the medical plan you chose to enroll in (or to the SEBB Program if only enrolling the child in dental and/or vision coverage). 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.

Currently eligible employees: No later than the last day of the SEBB Program's annual open enrollment, or 60 days after a qualifying special open enrollment event. See the HCA website at **hca.wa.gov/sebb-employee** under *Change your coverage* for a list of qualifying events.

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

SEBB Continuation Coverage (COBRA or Unpaid Leave) subscribers

1. Complete and submit the appropriate SEBB election or change form to the SEBB Program.
2. Send this certification form to the medical plan you chose to enroll in (or to the SEBB Program if only enrolling the child in dental and/or vision coverage). Address information is on the next page.

Forms must be received within the timelines described below:

Current continuation coverage 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. See the HCA website at **hca.wa.gov/sebb-continuation** under *Change your coverage* for a list of qualifying events.

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.**

* 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.

C Recertification instructions

If your child with a disability is currently enrolled and it is time to recertify their eligibility:

Your medical plan or the SEBB Program must periodically review the disability status of your currently enrolled child with a disability following a previous certification. Your medical plan (or the SEBB Program if the child is enrolled only in dental and/or vision coverage) must receive this completed certification form **by the SEBB health plan coverage termination date** listed in the recertification request letter mailed to you.

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
Phone: 1-800-200-1004

For medical coverage (with or without dental/vision coverage), send this form to your medical plan at the address below.

⚠ If you intend to cover your child with a disability with medical coverage and you send this form to HCA in error, your coverage determination could be delayed or denied.

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

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 MS 137
PO Box 327
Seattle, WA 98111
Fax: 1-425-918-6335
Phone: 1-800-807-7310

Uniform Medical Plan

Regence BlueShield M/S BU231
333 Gilkey Road
Burlington, WA 98233
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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Type or print clearly in dark ink and use all capital lettering in the spaces provided.
Example: J O H N

Inaccurate, incomplete, or illegible information may delay coverage. Complete the "Subscriber information" and "Child with a disability information" sections. **Your child's provider must complete Sections 4 and 6, and may need to complete Section 5.**

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

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Subscriber's last name

Social Security number

Relationship to subscriber

Child

Stepchild

Extended dependent

What kind of certification is this?

New enrollment upon initial eligibility

Enrollment at age 26

Annual open enrollment change

Recertification

Special open enrollment change

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

Medical

Dental

Vision

Note: Retirees and their dependents must enroll in medical to enroll in dental.

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

Yes

No

If **yes**, attach a copy of the most recent SSI or SSDI Notice of Award letter. The letter must state that your child has been awarded SSI or SSDI based on being disabled. **Your child's provider must complete Sections 4 and 6.**

Child with a disability's employment information is required, to verify that the child with a disability is incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance. If left blank, certification may be denied.

Has this child ever been employed?

Yes

No

If **yes**, list all of 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:

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

The child's health care provider must complete Sections 4 and 6. Unless the subscriber attaches a copy of the most recent SSI or SSDI Notice of Award letter, the provider must also complete Section 5 on the next page. The subscriber must pay any fees for the provider to complete these sections.

Provider last name

First name | Middle initial | Suffix

National Provider Identifier (NPI) number

Mailing address (if different)

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

If **no**, what date did the disability first exist? (mm/dd/yyyy)

Subscriber's last name

Social Security number

5 Diagnosis and prognosis

Note to provider: Approval and duration of the child's disability certification for health plan coverage is based on the level of detail you provide about the child's diagnosis, prognosis, and necessity for support and ongoing care. **This information is not required if the child has been awarded SSI or SSDI based on being disabled.**

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

Prognosis
Please estimate the expected duration of the disability. This information is necessary to determine the approval duration of the child's disability certification.

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)