MOUNTAIN HEALTH CO-OP

Section 1 – Patient Information - to be completed by member/patient or subscriber/legal guardian

Member/Patient Name	Member/Patient Birthdate	Member ID
Subscriber Name and ID		Plan Name

Section 2 – Statement of Incapacitation - to be completed by the member/patients physician

Provider's Name				Provider's Telephone Number
Provider's Address	City	State	Zip Code	Provider's Tax ID Number

Date patient was last examined by physician	Nature of condition causing incapacity: ☐ Developmental Disability ☐ Medical Disability ☐ Mental Disorder ☐ Other (please explain)_____
Incapacitation Is: ☐ Complete ☐ Partial_____% Incapacitated	Incapacitation is: ☐ Temporary (estimated duration is)_____ ☐ Permanent At what age did patient become incapacitated?

Diagnosis of Condition Causing Incapacity: Please give as much detail as possible. Please give dates of surgery, forward laboratory data and results of special tests, such as x-rays, EKG's, EEG's, etc. Attach additional pages as necessary.

Diagnosis

Comments to Support Incapacity

Is patient or will patient be capable of self-support? ☐ Yes ☐ No
If yes, from _____

Is patient able to perform full or part-time work of any kind? ☐ Yes ☐ No

Has patient previously been able to perform full or part-time work of any kind? ☐ Yes ☐ No

Does patient have a job? ☐ Yes ☐ No ☐ Unknown	Do you know what duties the patient's job requires? ☐ Yes ☐ No If yes, please explain:

_____ _____
Physician's Name (please print) Physician's Credentials

_____ _____
Signature of Physician Date