VERMONT HEALTH CONNECT

Form No. SEPEC-01
Initial 04/2019

# Medical Incapacity Verification

Vermont Health Connect Special Enrollment Period Exceptional Circumstance

Customer Name: _____

**Physician - Return completed form to:**
Attn: Vermont Health Connect/HCAT
Fax: (802) 802-769-3237
Email: AHS-DVHASEPEC@vermont.gov

Last 4 of SSN: _____ Contact ID: _____

The Physician must complete and return this form as soon as possible to ensure that the customer does not lose the opportunity to enroll in health coverage. Medical incapacity for this purpose is narrowly defined as **a serious physical or mental infirmity that prevented the beneficiary from enrolling during open enrollment or the special enrollment period**. Examples of a serious infirmity might include dementia or an inpatient hospitalization stay.

The person below has claimed an infirmity so severe that it prevented enrollment into a Qualified Health Plan during annual open enrollment or special enrollment period. Rules require that a physician certify this claim. Please complete and return this form to the email or fax number listed above.

_____ _____
Patient Name *(please print)* Date of Birth

_____ _____
Address Telephone Number

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**The following portion of this form must be completed by a physician.** "Physician" includes Physicians, Psychiatrists, Physician Assistants, Nurse Practitioners, Nurses with prescriptive authority, and Licensed Alcohol Counselors.

Did this patient have a serious physical or mental infirmity that prevented him or her from enrolling into a Qualified Health Plan during the annual open enrollment period or special enrollment period? ☐ Yes ☐ No

If YES, please provide the clinical reasons that are the basis for your assessment: _____

_____

_____

_____

Infirmity Period:
Start Date *(mm/dd/yyyy)*: _____ End Date *(mm/dd/yyyy)*: _____

**This form must be completed in full in order to be considered for an exceptional circumstance special enrollment period.**
**Certified by:**

_____ _____
Physician's Name *(please print)* Provider Number

_____ _____
Address Telephone Number

_____ _____
Physician's Signature Date