**Illinois Life and Health Insurance Guaranty Association**
Relating to Life & Health of America, in Liquidation
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# Nursing/Assisted Living Facility Claim Submission Checklist

## WHAT YOU NEED TO KNOW BEFORE FILING A CLAIM

### HOW TO COMPLETE THIS CLAIM FORM

The **Claimant Statement section** of the claim form should be completed in its entirety by you or by your designated Power of Attorney.

The **Nursing Facility Provider section** should be completed in its entirety by the Director of Nursing or equivalent at your designated facility.

The **Attending Physician Statement section** should be completed in its entirety by your Primary Care Physician and/or the physician recommending Nursing Facility Care.

### CLAIM DOCUMENTATION NEEDED

You and your designated Power of Attorney will need to acquire the following documentation for this claim.

Fully completed claim form. Any information left blank will cause delay with your claim.
Itemized Nursing Facility billing statement showing dates, a description of the services performed, and the amounts you were charged for these services from your date of admission until current.
Copy of the facilities current license.
Copy of Power of Attorney document. (if applicable)
Completed Assignment of Benefits form if benefits are to be assigned.
Copy of hospital bill for any hospital confinement preceding Nursing Facility confinement.

** This information is necessary to process a claim for benefits. Once the information is received we will review the file. Should we require additional information be submitted to process the claim, you will be notified in writing. The information provided is for informational purposes only. It is not a guarantee or certification that benefits will be paid. Benefits due, it any, will be paid only in accordance with the terms and conditions of the policy and only after final claim papers have been received and any necessary investigation has been conducted. **

## NURSING/ASSISTED LIVING PART I- CLAIMANT'S STATEMENT
## TO BE COMPLETED BY CLAIMANT OF POWER OF ATTORNEY ONLY.

List All Policy Numbers:

_____ _____ _____

Full Name of claimant representing above policy number(s)

_____

Social Security Number _____ Date of Birth _____

Policyholder's Address _____

City _____ Country _____ State _____ Zip _____

Telephone Number _____ Email _____

Please check if this is a new address ☐

When did you first notice pain, discomfort or any indication of your condition? _____

Nature of sickness or injury _____

_____

Have you previously been treated for this condition? ☐ Yes ☐ No When? _____

Were you hospital confined? ☐ Yes ☐ No When? _____

If yes, name and address of hospital _____

_____

List name, address and phone number of your family doctor _____

_____

**PATIENT'S AUTHORIZATION**

I hereby authorize all physician, hospitals, clinics, medical practitioners, dispensaries, nursing homes, home health care agencies or other medically related facilities (including other insurance companies such as BCBS), or employer, governmental agency to permit the Illinois Life & Health Insurance Guarantee Association or its representative to obtain or review a copy of your records pertaining to the examination, treatment, history, prescription and medical expenses of the undersigned. A photostatic copy of this authorization shall be valid as the original. This authorization will only be valid for a total of 36 months or the resolution to this claimant's care.

Signature _____ Date _____

Name, address and phone number of person holding Power of Attorney (if applicable) _____

_____

Date Power of Attorney was effective _____

## PART II- NURSING HOME/ASSISTED LIVING FACILITY STATEMENT
## TO BE COMPLETED BY DIRECTOR OF NURSING

Give the current level of patient's functioning. **CHECK** the number that corresponds with the most accurate description listed below.

1. **Independent:** Can perform an activity by oneself with or without the aid of equipment or assistance of another person (including verbal guidance)
2. **Minimal Assistance Required:** Must have verbal guidance and partial or intermittent hand-assistance from another person.
3. **Moderate Assistance Required:** Must have assistance from another person with all or most of the activity.
4. **Dependent:** Does not participate in the activity and must be totally and continuously cared for by another person.

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**Bathing:** Ability to wash oneself completely in tub, shower, or by sponge bath

○ 1 ○ 2 ○ 3 ○ 4

**Eating:** Ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils.

○ 1 ○ 2 ○ 3 ○ 4

**Dressing:** Ability to put on and take off all garments and/or medically necessary braces or artificial limbs.

○ 1 ○ 2 ○ 3 ○ 4

**Toileting:** Ability to do all of the following: (a) Get oneself to and from the toilet; (b) Get on and off the toilet; and (c) Maintain reasonable level of personal hygiene for the body.

○ 1 ○ 2 ○ 3 ○ 4

**Transferring:** Ability to move in and out of a chair (including a wheelchair), or bed.

○ 1 ○ 2 ○ 3 ○ 4

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1. Does the patient appear to have difficulty with any of the following; Check the appropriate subject.

☐ Orientation ☐ Naming Objects ☐ Following Instructions ☐ Remembering ☐ Verbal Expression

2. Describe additional care you provide for this patient:_____

_____

_____

3. Please give type of license that was issued to your institution by the state and the date of expiration:

_____

If your institution has multiple licenses and/or multiple purposes, please indicate which wing, ward, or unit (including a separate room or apartment) the patient resident

_____

4. Are the services provided 24 hours a day by, or under the direction of a nurse? ☐ Yes ☐ No

5. _____

Number of RNs employed full-time?_____ Number of LPNs employed full-time?_____

Number of CNAs employed full-time?_____ Other _____

## PART II- NURSING HOME/ASSISTED LIVING FACILITY STATEMENT cont'd.

## TO BE COMPLETED BY DIRECTOR OF NURSING

6. At any given time is there a nurse on duty or on call in the same location as the patient? ☐ Yes ☐ No

7. Are daily clinical records maintained on each patient? ☐ Yes ☐ No

   If yes, will you forward, upon written request with authorization, the daily records of the patient?
   ☐ Yes ☐ No

   If no, how often are they kept? _____

8. Are the services to the policyholder being provided under a planned program of observation and treatments?
   ☐ Yes ☐ No

   If yes, is the program the supervision of a physician who is not the owner of employee of the facility and continued in accordance with the standards of medical practice for the sickness or injury that requires policyholder's confinement. ☐ Yes ☐ No

9. Does this institution have the appropriate methods and procedures for handling and administering drugs and biologicals?
   ☐ Yes ☐ No

10. Does this institution provide three full meals a day and accommodates special dietary needs?
    ☐ Yes ☐ No

11. Please list any days covered by Medicare: Start Date _____ Cut-off Date _____

12. Name and address of attending physician: _____

    _____

13. Is this physician employed by the Nursing/Assisted Living Facility? ☐ Yes ☐ No

    If yes, please explain title: _____

14. Diagnosis: _____

15. Admit date: _____ Discharge date: _____

16. What level of care was the patient admitted to:
    ☐ SKILLED ☐ INTERMEDIATE ☐ CUSTODIAL ☐ OTHER, please explain: _____

17. Is your facility licensed by the appropriate federal or state agency to engage primarily in providing nursing care and related services to inpatients? ☐ Yes ☐ No

18. Is the patient still residing in the same unit as of today's date? ☐ Yes ☐ No

19. Any additional information you wish to provide? _____

    _____

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Signature: _____ Date: _____

Title: _____ Email: _____

Facility Name & Address: _____

_____

Phone: _____ Fax: _____

Tax ID: _____

***** PLEASE SEND A COPY OF YOUR OPERATION LICENSE AND COPIES OF ANY BILLS THIS CLAIMANT HAS INCURRED ALONG WITH THIS CLAIM FORM. YOUR ASSISTANCE IS VERY MUCH APPREICATED! *****

## PART III- ATTENDING PHYSICIAN'S STATEMENT

## THIS SECTION MUST BE COMPLETED & SIGNED BY THE PHYSICIAN RECOMMENDING LONG-TERM CARE CONFINEMENT

Patient Name:_____ Date Completed:_____

1. Hospital/SNF/Rehab admission in the past 6 months:

| Institution | City/State | Admitted | Discharge | Diagnosis |
|---|---|---|---|---|
| | | | | |
| | | | | |

2. Past Medical History including diagnosis with date of onset:

3. Name, address & phone number of referring physician:

4. Diagnosis for Nursing Facility Care:

5. Please tell us why this patient would require Nursing Facility Care for the above diagnosis:

### FUNCTIONAL ABILITIES

**CHECK** the level of assistance your patient requires with the following activities:

**Standby**- Must have verbal guidance and partial or intermittent hand-assistance from another person.

**Hands On**- Must have assistance from another person with all or most of the activity.

**Total**- Does not participate int the activity and must be totally continuously cared for by another person.

| ACTIVITIES OF DAILY LIVING | | | | |
|---|---|---|---|---|
| **Eating** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Toileting** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Dressing** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Bathing** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Ambulation** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Transfer** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Mobility** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **INSTRUMENTAL ACTIVITIES OF DAILY LIVING** | | | | |
| **Housekeeping** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Meal Prep** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Shopping** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Transportation** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Medication** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |
| **Laundry** | ◯ No Assistance | ◯ Standby Asst. | ◯ Hands-On Asst. | ◯ Total Asst. |

## PART III- ATTENDING PHYSICIAN'S STATEMENT cont'd.

## THIS SECTION MUST BE COMPLETED & SIGNED BY THE PHYSICIAN RECOMMENDING LONG-TERM CARE CONFINEMENT

**Bowel/Bladder** ☐ Continent ☐ Incontinent ☐ Foley Catheter ☐ Ostomy ☐ Other: _____

**Vision** ☐ Normal/Corrected ☐ Impaired ☐ Blind ☐ Glasses/Contacts

**Hearing** ☐ Normal/Corrected ☐ Impaired ☐ Deaf ☐ Hearing Aids ☐ R ☐ L

**Mental Status** ☐ Alert & Oriented ☐ Forgetful* ☐ Confused

6. What equipment does this patient use?
   ☐ Cane ☐ Walker ☐ Bedside Commode ☐ Wheel Chair ☐ Hospital Bed ☐ Seat Lift Chair ☐ Hoyer Life ☐ Raised Toilet Seat
7. What level of care does this patient require? ☐ Assisted ☐ Independent
   Other Please explain: _____
8. How long do you anticipate this level of care will last? _____
9. Is this care medically necessary? ☐ Yes ☐ No
10. Is this care in lieu of hospital confinement? ☐ Yes ☐ No
11. Is this care to provide personal or medical care to the patient? ☐ Yes ☐ No
12. Date care started or should start: _____ Date care should end: _____

COGNITIVE CAPACITY if applicable

Please provide your opinion below as to what cognitive impairment, if any, your patient has experienced. We have provided a definition of cognitive impairment below for your reference.

**Cognitive Impairment-** An insured has suffered a deterioration of loss in their intellectual capacity which requires another person's assistance or verbal cueing to protect them to other as measured by clinical evidence and standardized tests which reliably measure impairment in the following areas:

a. Short or long-term memory
b. Orientation as to person (such as who they are), place (such as their location) and time (such as day, date, year)
c. Deductive or abstract reasoning

*** Such loss intellectual capacity can result from Alzheimer's disease or similar forms of cognitive impairment.

13. Does your patient have a cognitive impairment: ☐ Yes ☐ No
14. What is the cognitive impairing diagnosis (please be specific): _____
15. When was your patient first seen for cognitive issues and by whom? (mm/dd/yy)
    _____
16. Has any cognitive testing been completed? ☐ Yes ☐ No
    If yes, please attach results from testing with this form.

## PART III- ATTENDING PHYSICIAN'S STATEMENT cont'd.
## THIS SECTION MUST BE COMPLETED & SIGNED BY THE PHYSICIAN RECOMMENDING LONG-TERM CARE CONFINEMENT

17. Is your patient's cognitive impairment to the degree that puts him/her at risk for health & safety?

☐ Yes ☐ No

If yes, when did the cognitive impairment begin to impair your patient's judgement? (mm/dd/yy): _____

If yes, please indicate why supervision is needed as well as what activities your patient needs assistance/supervision with?

Why:

☐ Short-Term memory loss ☐ Long-Term memory loss ☐ Poor Judgement

☐ Wandering behavior ☐ Impaired executive function ☐ Impaired orientation to person/place

☐ Confusion ☐ Other _____

What activities:

☐ Managing Finances ☐ Managing Medications ☐ Using telephone/devices

☐ Handling Transportation ☐ Shopping ☐ Meal Prep ☐ Housework

18. Do you know whether your patient is still driving? ☐ Yes ☐ No ☐ Unknown

19. If your patient is driving, do you agree that he/she should be driving? ☐ Yes ☐ No

**ATTENDING PHYSICIAN'S CERTIFICATION**

I ☐ certify ☐ **recertify that the above service are required and authorized by myself with a written plan for treatment which will be periodically reviewed by myself. This patient is under my care and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need.**

**Signature X**_____ **Date** _____

Physician Name/Practice (Print) _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____