



## Illinois Life and Health Insurance Guaranty Association

PO Box 4198 Lisle, IL 60532  
Phone (773) 444-4071 Fax (773) 304-3559

[PTInquiry@illinoisga.org](mailto:PTInquiry@illinoisga.org) *(secure method preferred)*

### Nursing 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 in order 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, if 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. \*\*

**PART I- CLAIMANT'S STATEMENT**  
**TO BE COMPLETED BY CLAIMANT OR 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 \_\_\_\_\_ 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 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.

<b>Bathing:</b>	Ability to wash oneself completely in tub, shower, or by sponge bath	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Eating:</b>	Ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Dressing:</b>	Ability to put on and take off all garments and/or medically necessary braces or artificial limbs.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Toileting:</b>	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.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Transferring:</b>	Ability to move in and out of a chair (including a wheelchair), or bed.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

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 resides at.  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Does this institution provide 24 hour a day nursing services?                      Yes      No  
 Please provide the number of individuals assigned to each healthcare provider at any given time:  
 \_\_\_\_\_
5. Number of RNs employed full-time? \_\_\_\_\_ Number of LPNs employed full-time? \_\_\_\_\_  
 Number of CNAs employed full-time? \_\_\_\_\_ Other \_\_\_\_\_

**NURSING FACILITY STATEMENT cont'd.**  
**TO BE COMPLETED BY DIRECTOR OR NURSING**

6. At any given time is there a nurse on duty or on call at all times 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 an authorization, the daily records of the patient?

Yes      No

If no, how often are they kept? \_\_\_\_\_

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

9. Does this institution provide three full meals a day and accommodates special dietary needs?

Yes      No

10. Please list any days covered by Medicare

Start Date \_\_\_\_\_ Cut-off Date \_\_\_\_\_

11. Name and address of attending physician: \_\_\_\_\_

12. Is this physician employed by the Nursing Facility?      Yes      No

If yes, please explain title: \_\_\_\_\_

13. Diagnosis: \_\_\_\_\_

14. Admission date: \_\_\_\_\_ Discharge date: \_\_\_\_\_

15. What level of care was patient admitted to: (Check one in each category)

SKILLED    INTERMEDIATE    CUSTODIAL    Other, please explain: \_\_\_\_\_

16. 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

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

18. Any additional information you wish to provider? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Facility Name & Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

TAX ID: \_\_\_\_\_

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

**PART III – ATTENDING PHYSICIAN’S STATEMENT**  
**THIS SECTION MUST BE COMPLETED & SIGNED BY THE PHYSICIAN RECOMMENDING NURSING FACILITY CARE**

Patient Name: \_\_\_\_\_

Date Completed: \_\_\_\_\_

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

Institution	City/State	Admitted	Discharge	Diagnosis

Past Medical History including diagnosis with date of onset:

\_\_\_\_\_

\_\_\_\_\_

Name, address & phone number of referring physician:

\_\_\_\_\_

Diagnosis for Nursing Facility Care:

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FUNCTIONAL ABILITIES**

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

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

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

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

**Activities of Daily Living**

	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
<b>Eating</b>				
<b>Toileting</b>				
<b>Dressing</b>				
<b>Bathing</b>				
<b>Ambulation</b>				
<b>Transfer</b>				
<b>Mobility</b>				

**Instrumental Activities of Daily Living**

<b>Housekeeping</b>	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
<b>Meal preparation</b>	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
<b>Shopping</b>	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
<b>Transportation</b>	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
<b>Managing Medicines</b>	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
<b>Laundry</b>	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance

**ATTENDING PHYSICIAN STATEMENT cont'd.**

**TO BE COMPLETED BY PHYSICIAN RECOMMENDING NURSING HOME FACILITY CARE**

<b>Bowel/Bladder</b>	<b>Continent</b>	<b>Incontinent</b>	<b>Foley Catheter</b>	<b>Ostomy</b>	<b>Other</b> _____
<b>Vision</b>	<b>Normal/Corrected</b>	<b>Impaired</b>	<b>Blind</b>	<b>Glasses/Contacts</b>	
<b>Hearing</b>	<b>Normal/Corrected</b>	<b>Impaired</b>	<b>Deaf</b>	<b>Hearing Aids:</b>	<b>R</b> <b>L</b>
<b>Mental Status</b>	<b>Alert &amp; Oriented</b>	<b>Forgetful*</b>	<b>Confused*</b>		

What equipment does this patient use?:

Cane	Walker	Bedside Commode
Wheel Chair	Hospital Bed	Seat Lift Chair
Hoyer Life	Raised Toilet Seat	

What level of care does this patient require:      Assisted      Independent      Other

Please explain \_\_\_\_\_

How long do you anticipate this level of care will last? \_\_\_\_\_

Is this care medically necessary?      Yes      No

Is this care in lieu of a hospital confinement?      Yes      No

Is this care to provide personal or medical care to patient?      Yes      No

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 or 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.

Does your patient have a cognitive impairment:      Yes      No

What is the cognitively impairing diagnosis (please be specific): \_\_\_\_\_

When was your patient first seen for cognitive issues and by whom? (mm/dd/yy): \_\_\_\_\_

Has any cognitive testing been completed?      Yes      No      If yes, please attach testing with this form.

If no cognitive testing has been performed, please attach clinical findings that support a cognitive impairment.

**ATTENDING PHYSICIAN STATEMENT cont'd.**

**TO BE COMPLETED BY PHYSICIAN RECOMMENDING NURSING HOME FACILITY CARE**

Is your patient's cognitive impairment to the degree that it puts him/her at risk for health and safety? Yes    No

If yes, when did the cognitive impairment begin to impair your patient 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

**What activities:**

Managing Finances                  Managing Medications                  Using telephone/devices                  Handling Transportation

Shopping                  Preparing Meals                  Housework/Home Management

Do you know whether or not your patient is still driving? Yes    No    Unknown

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's Name (please print) \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_