



Illinois Life and Health Insurance Guaranty Association

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ILClaims@illinoisga.org (secure method preferred)

Home Health Care 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 **Home Health Care Provider section** should be completed in its entirety by your designated Home Health Care Provider.

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

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 billing statements showing the dates of service and daily/hourly rates.
- Copy of Agency's and Caregiver's License/Certification.
- Copy of Power of Attorney document. (if applicable)

** 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- HOME HEALTH CARE PROVIDER STATEMENT
TO BE COMPLETED BY HOME CARE AGENCY REPRESENTATIVE**

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.

| | | | | | |
|----------------------|--|----------|----------|----------|----------|
| 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 |

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. Provider name: _____ Agency Private Worker
4. Address: _____
 City: _____ Country: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 TAX ID/ S.S: _____
5. State License/Certification: _____ Number: _____
6. If you are not licensed/certified, list your qualifications for providing home health care:

7. Are you a member of the Insured's family? Yes No
 Relationship to Claimant: _____
 Do you live with the Claimant? Yes No If yes, for how long have you lived with them? _____

**HOME HEALTH CARE PROVIDER STATEMENT cont'd.
TO BE COMPLETED BY HOME CARE AGENCY REPRESENTATIVE**

8. What is the estimated charge to the client for home health care services:
\$ _____/HR \$ _____/ DAY

9. Are any of these charges being submitted to other payers? Describe:

10. Start of care date: _____ Discharge date: _____

Comments:

Signature: _____ Date: _____

Title: _____

*****PLEASE ATTACH A COPY OF LICENSE/CERTIFICATION TO THIS FORM ALONG WITH THIS CLAIM FORM. WE WILL REQUIRE PATIENT ASSESSMENT FORMS, DAILY PROGRESS NOTES AND ITEMIZED BILLING PRIOR TO ADMINSTRERING ANY PAYABLE BENEFITS. YOUR ASSISTANCE IS VERY MUCH APPRECIATED *****

PART III – ATTENDING PHYSICIAN’S STATEMENT
THIS SECTION MUST BE COMPLETED & SIGNED BY THE PHYSICIAN RECOMMENDING HOME HEALTH CARE SERVICES.

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 Home Health Care:

Please tell us why this patient would require Home Health 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 |
|-------------------|---------------|--------------------|---------------------|------------------|
| Eating | | | | |
| Toileting | | | | |
| Dressing | | | | |
| Bathing | | | | |
| Ambulation | | | | |
| Transfer | | | | |
| Mobility | | | | |

Instrumental Activities of Daily Living

| | No Assistance | Standby Assistance | Hands On Assistance | Total Assistance |
|---------------------------|---------------|--------------------|---------------------|------------------|
| Housekeeping | | | | |
| Meal preparation | | | | |
| Shopping | | | | |
| Transportation | | | | |
| Managing Medicines | | | | |
| Laundry | | | | |

ATTENDING PHYSICIAN STATEMENT cont'd.

TO BE COMPLETED BY PHYSICIAN RECOMMENDING HOME HEALTH CARE

| | | | | | |
|----------------------|-----------------------------|--------------------|-----------------------|-------------------------|--------------------|
| 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* | | |

***PLEASE SPECIFY TEST RESULTS USED IN DIAGNOSING COGNITIVE IMPAIRMENT:**

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: _____ # of hours per day _____ # of hours per week _____

Skilled care of RN, LPN, PT, OT, ST, MSW

Home Health Aide/CNA

Homemaker

Sitter/Companion

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 or nursing 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: _____

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

| | |
|---|--|
| <p>ATTENDING PHYSICIAN'S CERTIFICATION</p> <p>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.</p> <p>Signature X _____ Date _____</p> | |
|---|--|

Physician's Name (please print) _____ Phone: _____

Address: _____ Fax: _____