Illinois Life and Health Insurance Guaranty Association

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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, 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. **

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**

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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. 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

Eating	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
Toileting	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
Dressing	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
Bathing	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
Ambulation	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
Transfer	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance
Mobility	No Assistance	Standby Assistance	Hands On Assistance	Total Assistance

Instrumental Activities of Daily Living

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

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

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: _______________________________