



Illinois Life and Health Insurance Guaranty Association  
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## Monthly Care Certification

*This form must be completed by facility staff only; incomplete forms will delay adjudication of the claim.*

### Resident and Facility Information

- Resident name: \_\_\_\_\_ Policy: \_\_\_\_\_
- Facility Name: \_\_\_\_\_
- Contact person: \_\_\_\_\_ Title: \_\_\_\_\_  
 Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

### Confinement Information

All of the following questions must be completed for each month being claimed for benefits. Please attach and submit the billing statement from the facility **for the dates covered in this certification** with this form to one the preferred methods above. Do not submit until after month's end.

- This form is submitted for service dates: \_\_\_\_\_ **through** \_\_\_\_\_  
 Discharge date: \_\_\_\_\_
- Was the resident out of the facility overnight?** Yes No *if yes, complete the following:*  
 Bed hold charge? Yes No  
 Left on: \_\_\_\_\_ Returned on: \_\_\_\_\_ Due to: Hospital Other \_\_\_\_\_  
 Left on: \_\_\_\_\_ Returned on: \_\_\_\_\_ Due to: Hospital Other \_\_\_\_\_
- Care level:** Skilled Intermediate Assisted Living Other \_\_\_\_\_
- Current Diagnosis:** \_\_\_\_\_

**Please indicate with a check mark the level of assistance provided by the facility staff with the following activities:**

Activities of Daily Living (ADLs)	Bathing/ Showering	Indoor mobility/walking	Getting in/out of bed/chair	Continence care bladder/bowel	Eating	Toileting	Dressing	Medication
Independent								
Supervision								
Standby Assistance								
Hands-On Assistance								

- Was prompting, cueing or supervision provided?** Yes No
- Does the resident use any of the following?**  
 Cane Walker Wheelchair Other \_\_\_\_\_
- Are any of the dates above covered by Medicare** Yes No  
 If yes, list Paid-In Full and Coinsurance dates: \_\_\_\_\_

If the facility statement does not reflect payments made by Medicare, Medicaid or other sources for the same period that reduces the resident's liability for charges, please attach payment information for the dates in this submission.

For your protection, state insurance laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signed \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_