

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

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HOME HEALTH CARE RECERTIFICATION

BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM, THE COMPANY SHALL NOT BE HELD
TO ADMIT VALIDITY OF ANY CLAIM OR TO WAIVE ANY OF ITS RIGHTS OR ANY OF THE CONDITIONS OF THE POLICY

POLICYHOLDER NAME _____

POLICY #: _____

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE# _____

1. What is the nature of your condition? _____

2. Has there been a change in your health condition? _____

3. State between what dates, if any, you were	Confined to a hospital.....From _____ To _____
	Confined to a rehabilitation facility..... From _____ To _____
	Confined to a skilled nursing unit or facility..... From _____ To _____

If confined, please provide details regarding the facility:

NAME _____ ADDRESS _____ PHONE _____

NAME _____ ADDRESS _____ PHONE _____

NAME _____ ADDRESS _____ PHONE _____

DATE _____

SIGNED _____

PHYSICIAN'S SUPPLEMENTARY REPORT

1. Past Medical History including diagnosis with date of onset: _____

What complications, if any, have arisen? (Describe fully) _____

2. Diagnosis for Home Health Care: _____

3. Please tell us why this patient would require Home Health Care for the above diagnosis: _____

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	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Toileting	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Dressing	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Bathing	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Ambulation	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Transfer	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Mobility	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance

Instrumental Activities of Daily Living

Housekeeping	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Meal preparation	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance

Shopping	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Transportation	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Managing Medicines	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Laundry	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance

Bowel/Bladder	<input type="checkbox"/>	Continent	<input type="checkbox"/>	Incontinent	<input type="checkbox"/>	Foley Catheter	<input type="checkbox"/>	Ostomy	<input type="checkbox"/>	Other	
Vision	<input type="checkbox"/>	Normal/Corrected	<input type="checkbox"/>	Impaired	<input type="checkbox"/>	Blind	<input type="checkbox"/>	Glasses/Contacts			
Hearing	<input type="checkbox"/>	Normal/Corrected	<input type="checkbox"/>	Impaired	<input type="checkbox"/>	Deaf	<input type="checkbox"/>	Hearing Aids:	<input type="checkbox"/>	R <input type="checkbox"/>	L
Mental Status	<input type="checkbox"/>	Alert & Oriented	<input type="checkbox"/>	Forgetful*	<input type="checkbox"/>	Confused*					

*PLEASE SPECIFY TEST RESULTS USED IN DIAGNOSING COGNITIVE IMPAIRMENT:

4. What equipment does this patient use?:

<input type="checkbox"/>	Cane	<input type="checkbox"/>	Walker	<input type="checkbox"/>	Bedside Commode	<input type="checkbox"/>	Wheel Chair
<input type="checkbox"/>	Hospital Bed	<input type="checkbox"/>	Seat Lift Chair	<input type="checkbox"/>	Hoyer Lift	<input type="checkbox"/>	Raised Toilet Seat

5. What level of care does this patient require:

<i>Provider Level of Care</i>	<i>Number of Hours/Day</i>	<i>Number of Hours/Week</i>
Skilled Care of RN, LPN, PT, OT, ST, MSW	<input type="text"/>	<input type="text"/>
Home Health Aide/C.N.A	<input type="text"/>	<input type="text"/>
Homemaker	<input type="text"/>	<input type="text"/>
Sitter/Companion	<input type="text"/>	<input type="text"/>

6. How long do you anticipate this level of care will last? _____

7. Is this care medically necessary? YES NO

8. Is this care in lieu of a hospital or nursing confinement? YES NO

9. Is this care to provide personal or medical care to patient? YES NO

10. Date care started or should start: _____ Date care should end: _____

11. Do you know whether or not your patient is still driving? YES NO UNK

12. If your patient is driving, do you agree that he/she should be driving? YES NO

PHYSICIAN RECERTIFICATION STATEMENT

I, 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 _____ **Date** _____

Print Physician/Practice Name _____ Phone _____

Street _____ City _____ State _____ Zip _____