

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

P. O. Box 4198, Lisle, Illinois 60532
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ILClaims@illinoisga.org



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

