Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306
Toll-Free: 1-800-228-6080
Claims Fax: 1-402-938-9459

ATTN: Claims Department

MONTHLY VERIFICATION OF CONTINUING CARE

PART A: INSTRUCTIONS FOR THE LONG-TERM CARE FACILITY

Complete Parts A & B for each month the resident is confined and attach the itemized bill.

(Use blue or black ink only.)

Form submitted for dates of service from ____________________ to ______________________

1. Resident Name____ Policy Number________________
2. Name of Long-Term Care Facility____
3. Facility Address____
____
4. Telephone Number (______)__________________________
5. Initial Admission Date________________________________
6. Discharge Date_____________________________________
7. Subsequent Admission(s)_______________________, ______________________, ______________________
8. Diagnosis on Admission____
9. Secondary Diagnosis____
10. ☐ Remained in the facility with NO out of facility date.
11. ☐ Remained in the facility with the exception of the following date(s).

    Left on ________________ Returned on ________________ Bed Hold Charge ☐ Yes ☐ No

    Reason____

    Left on ________________ Returned on ________________ Bed Hold Charge ☐ Yes ☐ No

    Reason____

    Left on ________________ Returned on ________________ Bed Hold Charge ☐ Yes ☐ No

    Reason____
12. Name of Attending Physician____
    Phone Number________________________
13. Is Resident's Stay Medicare-Approved? ☐ Yes ☐ No If yes, list dates approved_____________________
____
____

14. FACILITY'S EVALUATION OF RESIDENT'S LEVEL OF CARE					
	FROM	TO		FROM	TO
☐ Skilled	/ /	/ /	☐ Independent Living	/ /	/ /
☐ Intermediate	/ /	/ /	☐ Retirement Facility	/ /	/ /
☐ Assisted Living	/ /	/ /	☐ Other	/ /	/ /

Please see our website at www.gomedico.com for additional copies of forms.

MONTHLY VERIFICATION OF CONTINUING CARE, continued

PART B

RESIDENT'S NAME____ **POLICY #**____________________

MENTAL AND COGNITIVE STATUS:

15. Describe resident's assistance with medications.

☐ Facility policy to administer ☐ Resident self-administers ☐ Assistance provided

Describe____

16. Does your facility document in a clinical record? ☐ Yes ☐ No: If yes, how often?______________________

17. ACTIVITIES OF DAILY LIVING [ADLs]:

[ADLs]	Performs Completely Independently	Performs Independently Using Assistive Device	Able to Complete Only with Cueing or Supervision of Another Person	Requires Some Human Assistance with Certain Elements of Task	Requires Substantial Assistance from Another Person to Complete
Bathing/Showering/Sponge	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐
Continence Bladder/Bowel	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐

*Record details of any assistance needed, including type of assistance, how often it is provided, and who provides the assistance____

____

____

____

____

List any assistive devices used by resident (wheelchair, walker, cane, etc.)______________________________

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____

If more space is needed, attach a signed and dated sheet and check this box ☐.
(check only if additional sheet is submitted)

Signature of Director of Nursing or Nursing Manager____

Title ______________________________________ Date _____________________________________

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.