

## ATTENDING PHYSICIAN'S STATEMENT Must Be Completed By Physician

PATIENT'S NAME \_\_\_\_\_

Policy # \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Primary Diagnosis/ICD9 Code \_\_\_\_\_ Date of Onset \_\_\_\_\_  
Secondary Diagnosis/ICD9 Code \_\_\_\_\_ Date of Onset \_\_\_\_\_

2. Date you last saw this patient \_\_\_\_\_ Reason for visit \_\_\_\_\_

3. Are any of the following services necessary?  
Please check all that apply.

- |                    |                          |                        |                          |
|--------------------|--------------------------|------------------------|--------------------------|
| RN                 | <input type="checkbox"/> | Occupational Therapist | <input type="checkbox"/> |
| Certified Aide     | <input type="checkbox"/> | Speech Therapist       | <input type="checkbox"/> |
| Homemaker          | <input type="checkbox"/> | Other _____            | <input type="checkbox"/> |
| Physical Therapist | <input type="checkbox"/> |                        |                          |

4. Care Setting      Nursing Home                            Adult Day Care                        
Assisted Living Facility                    Other \_\_\_\_\_                        
Personal Residence                     

[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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence Bladder/Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Expected amount of care required: \_\_\_\_\_ Hrs/Day    \_\_\_\_\_ Days/Wk    \_\_\_\_\_ Weeks/Months

Note: Recommendations for the care described above are theoretical, based upon your observations. A definitive opinion of the need for the services is based upon all documentation including, but not limited to, assessments, medical records, and actual utilization of support services.

Failure to complete this form in full could possibly result in benefit qualifiers not being met. Use of "lifetime" and/or "99 years" is not acceptable for #6 unless insured has a terminal diagnosis or a severe progression of disease process.

7. Should this patient be capable of returning to prior level of independence with rehabilitation?  Yes     No  
If no, why \_\_\_\_\_

8. If this care was not available, would this patient require nursing facility confinement?  Yes     No  
If yes, why \_\_\_\_\_

Long-term care policies vary in the definitions of the Activities of Daily Living. This request is for general medical information. Additional medical information may be required.

Thank you for completing this form; please fax it to 402-938-9459.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Name and Address of Attending Physician \_\_\_\_\_