MEDICO®
INSURANCE COMPANY

PO Box 10386
Des Moines, IA 50306
Toll-Free: 1-800-228-6080
Claims Fax: 1-402-496-8199

ATTN: Claims Department

FACILITY CERTIFICATION OF CARE

INSTRUCTIONS FOR CLAIMANT:

1. **Please read and sign. (Use blue or black ink only.)**
2. **Give this form to the Long-Term Care Facility for completion.**

Claimant Name_____ Policy Number_____

Signature of Claimant_____ Date_____

INSTRUCTIONS FOR THE LONG-TERM CARE FACILITY:

1. Please complete this form, and attach a copy of:
   1) Physician's signed plan of care – including the diagnosis and treatments prescribed.
   2) Initial assessment.
   3) Copy of the license for the unit where the Insured is confined.
   4) Narrative charting, nurses notes and CNA flow sheets.
2. Please return the completed form and copies to the address above.

Name of Long-Term Care Facility_____

Facility Address_____

_____

Telephone Number (_____)_____ Number of Beds_____

Initial Admission Date_____

Discharge Date_____

Subsequent Admission(s)_____, _____, _____

Patient admitted from: ☐ Residence ☐ Hospital ☐ Other_____

Diagnosis on Admission_____

Secondary Diagnosis_____

Name of Attending Physician_____

Is Patient's Stay Medicare-Approved? ☐ Yes ☐ No If yes, list dates approved_____

_____

FACILITY'S EVALUATION OF PATIENT'S LEVEL OF CARE:

	FROM	TO		FROM	TO
☐ **Skilled**	/ /	/ /	☐ **Independent Living**	/ /	/ /
☐ **Intermediate**	/ /	/ /	☐ **Retirement Facility**	/ /	/ /
☐ **Assisted Living**	/ /	/ /	☐ **Other**	/ /	/ /

Please return the completed forms promptly to the address above.

FACILITY CERTIFICATION OF CARE, continued

PATIENT'S NAME_____ **Policy #**_____

MENTAL AND COGNITIVE STATUS:

Describe client's assistance with medications:

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

Describe_____

Does your facility document in a clinical record? ☐ Yes ☐ No If yes, how often?_____

Does the facility maintain control and records of medications given? ☐ Yes ☐ No

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_____

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

List any assistive devices used by patient (wheelchair, walker, cane, etc.)_____

FACILITY INFORMATION:

Does the facility have a Medical Director or MD available to furnish medical care in case of an emergency?
☐ Yes ☐ No

If yes, Name _____ Employee of facility? ☐ Yes ☐ No

Is there a nurse supervising care? ☐ Yes ☐ No
If yes, how often is the nurse physically present at the facility? _____ hrs/day _____ days/week

How often is nurse on call? _____ hr/day _____ days/week

Is this care provided under a physician's plan of care? ☐ Yes ☐ No
If yes, how often is the POC updated?_____

Signature of Director of Nursing or Nurse 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.