MEDICO® INSURANCE COMPANY

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

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 ☐ Occupational Therapist ☐
   Certified Aide ☐ Speech Therapist ☐
   Homemaker ☐ Other________________ ☐
   Physical Therapist ☐

4. Care Setting Nursing Home ☐ Adult Day Care ☐
   Assisted Living Facility ☐ Other________________ ☐
   Personal Residence ☐

5.

[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	☐	☐	☐	☐	☐

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 ______________________________

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