

CareAssist® Claim Form

INSTRUCTIONS FOR INSURED

1. Please read, sign and date this authorization to release information (*Please use blue or black ink only*).
2. Give this form to the Nursing Facility or Home Health Care Agency for completion.

I hereby authorized any Nursing Facility, Home Health Care Agency or any person who has attended me or examined me to furnish American Republic Corp Insurance Company, or it's representative, any all information with respect to my confinement in a nursing facility or my home health care, including records, progress notes, admitting and discharge orders, physician records or hospital records. A photographic copy of this authorization is as valid as the original.

Your Name

Policy Number

Your Signature

Date

INSTRUCTIONS FOR THE NURSING HOME OR HOME HEALTH CARE AGENCY

1. Please complete this form, and attach a copy of:
 - a). the physician's admission orders
 - b). hospital discharge orders
 - c). Medicare MDS assessment or facility health interview or nursing assessment
 - d). copy of your state license
2. Please return the completed form and copies to the address above.

Name of the Facility/Agency

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? If "Yes", list dates approved. . . YES NO

Date

Facility's Evaluation of Patient's Level of Care

	From	To		From	To
<input type="checkbox"/> Skilled	<input type="text" value="MM/ DD/ YYYY"/>	<input type="text" value="MM/ DD/ YYYY"/>	<input type="checkbox"/> Independent Living	<input type="text" value="MM/ DD/ YYYY"/>	<input type="text" value="MM/ DD/ YYYY"/>
<input type="checkbox"/> Intermediate	<input type="text" value="MM/ DD/ YYYY"/>	<input type="text" value="MM/ DD/ YYYY"/>	<input type="checkbox"/> Retirement Facility.....	<input type="text" value="MM/ DD/ YYYY"/>	<input type="text" value="MM/ DD/ YYYY"/>
<input type="checkbox"/> Assisted Living	<input type="text" value="MM/ DD/ YYYY"/>	<input type="text" value="MM/ DD/ YYYY"/>	<input type="checkbox"/> Other	<input type="text" value="MM/ DD/ YYYY"/>	<input type="text" value="MM/ DD/ YYYY"/>

Facility Certification of Care, continued

In lieu of completing this section, you may attach your state or facility assessment tool (or MDS) if it contains all of the information requested below. Please return the completed forms promptly to the address on the reverse side.

Patient's Name	Policy Number

Mental and Cognitive Status

Describe client's assistance with medications and please describe

Facility policy to administer Client self-administers Assistance provided

Does your facility document in a clinical record YES NO How often?

ACTIVITIES OF DAILY LIVING (ADL's)	PERFORMS COMPLETELY INDEPENDENTLY	ABLE TO PERFORM WITH ASSISTIVE DEVICE, BUT NO HUMAN ASSISTANCE*	ABLE TO PERFORM INDEPENDENTLY, BUT RECEIVES OR REQUESTS SOME HUMAN ASSISTANCE*	REQUIRES SOME HUMAN ASSISTANCE WITH CERTAIN ELEMENTS OF TASK*	REQUIRES HUMAN ASSISTANCE WITH ALL ELEMENTS OF TASK*
Bathing	<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"/>
Toileting	<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	<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"/>
NORMAL LIVING ACTIVITIES (NDL's)					
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping/Traveling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling Money/Bill Paying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*(Details of Needed Assistance. If more space is needed, attach a signed and dated sheet.)

Type of Assistance

Frequency of Assistance	Assistance Provider

Assistive Devices used by Patient (wheelchair, walker, cane, etc.)

Signature of Director/Administrator

X

For your Protection State Insurance Laws requires the following to appear on this form

FRAUD WARNING STATEMENT

Residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Residents of New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Residents of Tennessee: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

Residents of All Other States: For your protection, state law requires the following statement to appear on this form: **WARNING:** Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive is guilty of a crime and may be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The furnishing of forms does not constitute an admission of liability on the part of the Company.