American Republic Corp
Insurance Company
P.O. Box 14510, Des Moines, IA 50306-3510

# 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 authorize any Nursing Facility, Home Health Care Agency or any person who has attended me or examined me to furnish American Republic Insurance Company, or it's representative, 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

X

Date

MM/ DD/ YYYY

## 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 show at the end of this form.

**Name of the Facility/Agency**

**Address**

**Telephone Number**

**Number of Beds**

**Initial Admission Date**

MM/ DD/ YYYY

**Discharge Date**

MM/ DD/ YYYY

**Subsequent Admission(s)**

MM/ DD/ YYYY

MM/ DD/ YYYY

Patient admitted from:.. . . . . ☐ Residence ☐ Hospital ☐ Other MM/ DD/ YYYY

**Diagnosis on Admission**

**Secondary Diagnosis**

**Name of Attending Physician**

Is patient's stay Medicare-approved? If **"Yes"**, list dates approved. . . ☐ YES ☐ NO Date MM/ DD/ YYYY

**Facility's Evaluation of Patient's Level of Care**

| | From | To | | From | To |
|---|---|---|---|---|---|
| ☐ Skilled . . . . . | MM / DD / YYYY | MM / DD / YYYY | ☐ Independent Living . . . . | MM / DD / YYYY | MM / DD / YYYY |
| ☐ Intermediate . . . . . | MM / DD / YYYY | MM / DD / YYYY | ☐ Retirement Facility. . . . . | MM / DD / YYYY | MM / DD / YYYY |
| ☐ Assisted Living . . . . . | MM / DD / YYYY | MM / DD / YYYY | ☐ Other . . . . . | MM / DD / YYYY | 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 at the end of this form.

**Patient's Name**

**Policy Number**

**Mental and Cognitive Status**

**Describe client's assistance with medications**

☐ 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 | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ | ☐ | ☐ |
| Toileting | ☐ | ☐ | ☐ | ☐ | ☐ |
| Transferring | ☐ | ☐ | ☐ | ☐ | ☐ |
| Continence | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eating | ☐ | ☐ | ☐ | ☐ | ☐ |
| **NORMAL LIVING ACTIVITIES (NDL's)** | | | | | |
| Meal Preparation | ☐ | ☐ | ☐ | ☐ | ☐ |
| Shopping/Traveling | ☐ | ☐ | ☐ | ☐ | ☐ |
| Light Housekeeping | ☐ | ☐ | ☐ | ☐ | ☐ |
| Laundry | ☐ | ☐ | ☐ | ☐ | ☐ |
| Telephoning | ☐ | ☐ | ☐ | ☐ | ☐ |
| Handling Money/Bill Paying | ☐ | ☐ | ☐ | ☐ | ☐ |

*(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

**PLEASE RETURN COMPLETED FORM TO:**

American Republic Corp Insurance Company
Attention: Policy Claims
P. O. Box 14510 • Des Moines, IA 50306-3510

| For your protection state law requires the following statements to appear on this form. | |
|---|---|
| **FRAUD WARNING STATEMENT** | |
| **Alabama** | Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. |
| **Arkansas, Louisiana, and West Virginia** | Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| **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. |
| **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. |
| **Kansas** | Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be guilty of insurance fraud as determined by a court of law. Use of the mail to defraud is a violation of federal law. |
| **Kentucky** | Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. |
| **Maine, Tennessee, Virginia, and Washington** | It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits. |
| **New Mexico** | Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. |
| **Ohio** | Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. |
| **Oklahoma** | Any person who knowingly, and with intent to injure, defraud or deceive, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. |
| **Oregon** | Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud may be a violation of federal law. |
| **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 All Other States** | **NOTICE: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.** |
| The furnishing of forms does not constitute an admission of liability on the part of the Company. | |