Hawaii Life & Disability Insurance Guaranty Association
Relating to Penn Treaty, in Liquidation
1003 Bishop Street, Suite 2030 Honolulu, HI 96813
Phone (808) 749-4919
penntreatyaloha@hilifega.org *(secure method preferred)*

Home Health Care Claim Submission Checklist

WHAT YOU NEED TO KNOW BEFORE FILING A CLAIM

HOW TO COMPLETE THIS CLAIM FORM

The **Claimant Statement section** of the claim form should be completed in its entirety by you or by your designated Power of Attorney.

The **Home Health Care Provider section** should be completed in its entirety by your designated Home Health Care Provider.

The **Attending Physician Statement section** should be completed in its entirety by your Primary Care Physician and/or the physician recommending Home Health Care services.

CLAIM DOCUMENTATION NEEDED

You and your designated Power of Attorney will need to acquire the following documentation for this claim.

- ☐ **Fully completed claim form. Any information left blank will cause delay with your claim.**
- ☐ Itemized billing statements showing the dates of service and daily/hourly rates.
- ☐ Copy of Agency's and Caregiver's License/Certification.
- ☐ Copy of Power of Attorney document. (if applicable)

** This information is necessary in order to process a claim for benefits. Once the information is received we will review the file. Should we require additional information be submitted to process the claim, you will be notified in writing. The information provided is for informational purposes only. It is not a guarantee or certification that benefits will be paid. Benefits due, it any, will be paid only in accordance with the terms and conditions of the policy and only after final claim papers have been received and any necessary investigation has been conducted. **

PART I- CLAIMANT'S STATEMENT
TO BE COMPLETED BY CLAIMANT OR POWER OF ATTORNEY ONLY.

List All Policy Numbers:

_____ _____ _____

Full Name of claimant representing above policy number(s)_____

Social Security Number _____ Date of Birth _____

Policyholder's Address _____

City _____Country _____State _____Zip _____

Telephone Number _____ Please check if this is a new address ☐

When did you first notice pain, discomfort or any indication of your condition? _____

Nature of sickness or injury _____

_____

Have you previously been treated for this condition? ☐ Yes ☐ No When?_____

Were you hospital confined? ☐ Yes ☐ No When? _____

If yes, name and address of hospital _____

_____

List name, address and phone number of your family doctor _____

_____

PATIENT'S AUTHORIZATION

I hereby authorize all physician, hospitals, clinics, medical practitioners, dispensaries, nursing homes, home health care agencies or other medically related facilities (including other insurance companies such as BCBS), or employer, governmental agency to permit the Hawaii Life & Disability Insurance Guaranty Association or its representative to obtain or review a copy of your records pertaining to the examination, treatment, history, prescription and medical expenses of the undersigned. A photostatic copy of this authorization shall be valid as the original. This authorization will only be valid for a total of 36 months or the resolution to this claimant's care.

Signature_____ Date _____

Name, address and phone number of person holding Power of Attorney (if applicable)_____

_____

Date Power of Attorney was effective _____

PART II- HOME HEALTH CARE PROVIDER STATEMENT
TO BE COMPLETED BY HOME CARE AGENCY REPRESENTATIVE

Give the current level of patient's functioning. **CHECK** the number that corresponds with the most accurate description listed below.

1. **Independent:** Can perform an activity by oneself with or without the aid of equipment or assistance of another person (including verbal guidance)
2. **Minimal Assistance Required:** Must have verbal guidance and partial or intermittent hand-assistance from another person.
3. **Moderate Assistance Required:** Must have assistance from another person with all or most of the activity.
4. **Dependent:** Does not participate in the activity and must be totally and continuously cared for by another person.

Bathing: Ability to wash oneself completely in tub, shower, or by sponge bath
◯ **1** ◯ **2** ◯ **3** ◯ **4**

Eating: Ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils.
◯ **1** ◯ **2** ◯ **3** ◯ **4**

Dressing: Ability to put on and take off all garments and/or medically necessary braces or artificial limbs.
◯ **1** ◯ **2** ◯ **3** ◯ **4**

Toileting: Ability to do all of the following: (a) Get oneself to and from the toilet; (b) Get on and off the toilet; and (c) Maintain reasonable level of personal hygiene for the body.
◯ **1** ◯ **2** ◯ **3** ◯ **4**

Transferring: Ability to move in and out of a chair (including a wheelchair), or bed.
◯ **1** ◯ **2** ◯ **3** ◯ **4**

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1. Does the patient appear to have difficulty with any of the following; Check the appropriate subject.

☐ Orientation ☐ Naming Objects ☐ Following Instructions ☐ Remembering ☐ Verbal Expression

2. Describe additional care you provide for this patient:_____

_____

_____

3. Provider name: _____ ☐ Agency ☐ Private Worker
4. Address: _____
   City: _____ Country: _____ State: _____ Zip: _____
   Phone: _____ Fax: _____
   TAX ID/ S.S: _____
5. State License/Certification: _____ Number: _____
6. If you are not licensed/certified, list your qualifications for providing home health care:

_____

_____

_____

_____

7. Are you a member of the Insured's family? ☐ Yes ☐ No
   Relationship to Claimant: _____
   Do you live with the Claimant? ☐ Yes ☐ No If yes, for how long have you lived with them? _____

HOME HEALTH CARE PROVIDER STATEMENT cont'd.
TO BE COMPLETED BY HOME CARE AGENCY REPRESENTATIVE

8. What is the estimated charge to the client for home health care services:
   $ _____/HR $ _____/ DAY
9. Are any of these charges being submitted to other payers? Describe:
   _____
   _____
10. Start of care date: _____ Discharge date: _____
    Comments:
    _____
    _____
    _____
    _____

Signature: _____ Date:_____
Title: _____

*****PLEASE ATTACH A COPY OF LICENSE/CERTIFICATION TO THIS FORM ALONG WITH THIS CLAIM FORM. WE WILL REQUIRE PATIENT ASSESSMENT FORMS, DAILY PROGRESS NOTES AND ITEMIZED BILLING PRIOR TO ADMINSTRERING ANY PAYABLE BENEFITS. YOUR ASSISTANCE IS VERY MUCH APPRECIATED *****

PART III – ATTENDING PHYSICIAN'S STATEMENT
THIS SECTION MUST BE COMPLETED & SIGNED BY THE PHYSICIAN RECOMMENDING HOME HEALTH CARE SERVICES.

Patient Name: _____ Date Completed: _____

Hospital/SNF/Rehab admission in the past 6 months:

Institution	City/State	Admitted	Discharge	Diagnosis

Past Medical History including diagnosis with date of onset:

_____

_____

_____

Name, address & phone number of referring physician:

_____

_____

Diagnosis for Home Health Care:

_____

Please tell us why this patient would require Home Health Care for the above diagnosis:

_____

_____

_____

_____

FUNCTIONAL ABILITIES

CHECK the level of assistance you patient requires with the following activities:

Standby- Must have verbal guidance and partial or intermittent hands- assistance from another person.
Hands On- Must have assistance from another person with all or most of the activity.
Total- Does not participate in the activity and must be totally continuously cared for by another person.

Activities of Daily Living

Eating	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Toileting	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Dressing	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Bathing	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Ambulation	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Transfer	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Mobility	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance

Instrumental Activities of Daily Living

Housekeeping	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Meal preparation	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Shopping	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Transportation	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Managing Medicines	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Laundry	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance

ATTENDING PHYSICIAN STATEMENT cont'd.

TO BE COMPLETED BY PHYSICIAN RECOMMENDING HOME HEALTH CARE

Bowel/Bladder	☐ **Continent**	☐ **Incontinent**	☐ **Foley Catheter**	☐ **Ostomy**	☐ **Other** _____
Vision	☐ **Normal/Corrected**	☐ **Impaired**	☐ **Blind**	☐ **Glasses/Contacts**	
Hearing	☐ **Normal/Corrected**	☐ **Impaired**	☐ **Deaf**	☐ **Hearing Aids:** ☐ **R**	☐ **L**
Mental Status	☐ **Alert & Oriented**	☐ **Forgetful***	☐ **Confused***		

***PLEASE SPECIFY TEST RESULTS USED IN DIAGNOSING COGNITIVE IMPAIRMENT:**

_____

_____

What equipment does this patient use?:

☐ Cane	☐ Walker	☐ Bedside Commode
☐ Wheel Chair	☐ Hospital Bed	☐ Seat Lift Chair
☐ Hoyer Life	☐ Raised Toilet Seat	☐

What level of care does this patient require:	# of hours per day	# of hours per week
Skilled care of RN, LPN, PT, OT. ST, MSW		
Home Health Aide/CNA		
Homemaker		
Sitter/Companion		

How long do you anticipate this level of care will last? _____

Is this care medically necessary? ☐ Yes ☐ No

Is this care in lieu of a hospital or nursing confinement? ☐ Yes ☐ No

Is this care to provide personal or medical care to patient? ☐ Yes ☐ No

Date care started or should start: _____ Date care should end: _____

Do you know whether or not your patient is still driving? ☐ Yes ☐ No ☐ Unknown

If your patient is driving, do you agree that he/she should be driving? ☐ Yes ☐ No

ATTENDING PHYSICIAN'S CERTIFICATION

I ☐ certify ☐ recertify that the above service are required and authorized by myself with a written plan for treatment which will be periodically reviewed by myself. This patient is under my care and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need.

Signature X_____ Date _____

Physician's Name (please print) _____ Phone: _____

Address: _____ Fax: _____