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)*

Nursing Facility 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 **Nursing Facility Provider section** should be completed in its entirety by the Director of Nursing or equivalent at your designated facility.

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

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 Nursing Facility billing statement showing dates, a description of the services performed, and the amounts you were charged for these services from your date of admission until current.
- ☐ Copy of the facilities current license.
- ☐ Copy of Power of Attorney document. (if applicable)
- ☐ Completed Assignment of Benefits form if benefits are to be assigned.
- ☐ Copy of hospital bill for any hospital confinement preceding Nursing Facility confinement.

** 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- NURSING HOME FACILITY STATEMENT
TO BE COMPLETED BY DIRECTOR OF NURSING

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**

---

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. Please give type of license that was issued to your institution by the state and the date of expiration:

_____

If your institution has multiple licenses and/or multiple purposes, please indicate which wing, ward, or unit (including a separate room or apartment) the patient resides at.

_____

_____

4. Does this institution provide 24 hour a day nursing services? ☐ Yes ☐ No

Please provide the number of individuals assigned to each healthcare provider at any given time:

_____

5. Number of RNs employed full-time? _____ Number of LPNs employed full-time? _____

Number of CNAs employed full-time? _____ Other _____

NURSING FACILITY STATEMENT cont'd.
TO BE COMPLETED BY DIRECTOR OR NURSING

6. At any given time is there a nurse on duty or on call at all times in the same location as the patient? ☐ Yes ☐ No
7. Are daily clinical records maintained on each patient? ☐ Yes ☐ No

   If yes, will you forward, upon written request with an authorization, the daily records of the patient?

   ☐ Yes ☐ No

   If no, how often are they kept? _____
8. Does this institution have the appropriate methods and procedures for handling and administering drugs and biologicals?

   ☐ Yes ☐ No
9. Does this institution provide three full meals a day and accommodates special dietary needs?

   ☐ Yes ☐ No
10. Please list any days covered by Medicare

    Start Date _____ Cut-off Date _____
11. Name and address of attending physician: _____

    _____
12. Is this physician employed by the Nursing Facility? ☐ Yes ☐ No

    If yes, please explain title: _____
13. Diagnosis: _____

    _____
14. Admission date: _____ Discharge date: _____
15. What level of care was patient admitted to: (Check one in each category)

    ☐ SKILLED ☐ INTERMEDIATE ☐ CUSTODIAL ☐ Other, please explain: _____
16. Is your facility licensed by the appropriate federal or state agency to engage primarily in providing nursing care and related services to inpatients? ☐ Yes ☐ No
17. Is patient still residing in the same unit as of today's date? ☐ Yes ☐ No
18. Any additional information you wish to provider? _____

    _____

    _____

    _____

Signature: _____ Date: _____

Title: _____

Facility Name & Address: _____

_____

Phone: _____ Fax: _____

TAX ID: _____

******* PLEASE SEND A COPY OF YOUR OPERATING LICENSE AND COPIES OF ANY BILLS THIS CLAIMANT HAS INCURRED ALONG WITH THIS CLAIM FORM. YOUR ASSISTANCE IS VERY MUCH APPRECIATED! *******

PART III – ATTENDING PHYSICIAN'S STATEMENT
THIS SECTION MUST BE COMPLETED & SIGNED BY THE PHYSICIAN RECOMMENDING NURSING FACILITY CARE

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 Nursing Facility Care:

_____

Please tell us why this patient would require Nursing Facility 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 NURSING HOME FACILITY 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***

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: ☐ Assisted ☐ Independent ☐ Other

Please explain_____

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 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: _____

COGNITIVE CAPACITY *if applicable*

Please provide your opinion below as to what cognitive impairment, if any, your patient has experienced. We have provided a definition of cognitive impairment below for your reference.

Cognitive Impairment – An insured has suffered a deterioration of loss in their intellectual capacity which requires another person's assistance or verbal cueing to protect them or other as measured by clinical evidence and standardized tests which reliably measure impairment in the following areas:

(a) short or long-term memory:

(b) orientation as to person (such as who they are), place (such as their location) and time (such as day, date, year):

(c) **deductive or abstract reasoning**

** Such loss intellectual capacity can result from Alzheimer's disease or similar forms of cognitive impairment.

Does your patient have a cognitive impairment: ☐ Yes ☐ No

What is the cognitively impairing diagnosis (please be specific): _____

When was your patient first seen for cognitive issues and by whom? (mm/dd/yy):

_____

Has any cognitive testing been completed? ☐ Yes ☐ No If yes, please attach testing with this form.

If no cognitive testing has been performed, please attach clinical findings that support a cognitive impairment.

ATTENDING PHYSICIAN STATEMENT cont'd.

TO BE COMPLETED BY PHYSICIAN RECOMMENDING NURSING HOME FACILITY CARE

Is your patient's cognitive impairment to the degree that it puts him/her at risk for health and safety? ☐ Yes ☐ No

If yes, when did the cognitive impairment begin to impair your patient judgement? (mm/dd/yy) _____

If yes, please indicate why supervision is needed as well as what activities your patient needs assistance/supervision with?

Why:

☐ Short-Term memory loss ☐ Long-Term memory loss ☐ Poor Judgement ☐ Wandering Behavior

☐ Impaired executive function ☐ Impaired orientation to person/place ☐ Confusion

What activities:

☐ Managing Finances ☐ Managing Medications ☐ Using telephone/devices ☐ Handling Transportation

☐ Shopping ☐ Preparing Meals ☐ Housework/Home Management

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: _____