



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

[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	<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 Bladder/Bowel	<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"/>
Toileting	<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"/>

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 402-398-0898.

Physician Signature _____ Date _____

Name and Address of Attending Physician _____