



ATTN: Claims Department

MONTHLY VERIFICATION OF CONTINUING CARE

PART A: INSTRUCTIONS FOR THE LONG-TERM CARE FACILITY

Complete Parts A & B for each month the resident is confined and attach the itemized bill.

(Use blue or black ink only.)

Form submitted for dates of service from _____ to _____

1. Resident Name _____ Policy Number _____
2. Name of Long-Term Care Facility _____
3. Facility Address _____
4. Telephone Number (____) _____
5. Initial Admission Date _____
6. Discharge Date _____
7. Subsequent Admission(s) _____, _____, _____
8. Diagnosis on Admission _____
9. Secondary Diagnosis _____
10. Remained in the facility with NO out of facility date.
11. Remained in the facility with the exception of the following date(s).

Left on _____	Returned on _____	Bed Hold Charge <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason _____			
Left on _____	Returned on _____	Bed Hold Charge <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason _____			
Left on _____	Returned on _____	Bed Hold Charge <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason _____			
12. Name of Attending Physician _____
 Phone Number _____
13. Is Resident's Stay Medicare-Approved? Yes No If yes, list dates approved _____

14. FACILITY'S EVALUATION OF RESIDENT'S LEVEL OF CARE					
	FROM	TO		FROM	TO
<input type="checkbox"/> Skilled	/ /	/ /	<input type="checkbox"/> Independent Living	/ /	/ /
<input type="checkbox"/> Intermediate	/ /	/ /	<input type="checkbox"/> Retirement Facility	/ /	/ /
<input type="checkbox"/> Assisted Living	/ /	/ /	<input type="checkbox"/> Other	/ /	/ /

MONTHLY VERIFICATION OF CONTINUING CARE, continued

PART B

RESIDENT'S NAME _____ POLICY # _____

MENTAL AND COGNITIVE STATUS:

15. Describe resident's assistance with medications.

Facility policy to administer Resident self-administers Assistance provided

Describe _____

16. Does your facility document in a clinical record? Yes No: If yes, how often? _____

17. ACTIVITIES OF DAILY LIVING [ADLs]:

[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"/>

*Record details of any assistance needed, including type of assistance, how often it is provided, and who provides the assistance _____

List any assistive devices used by resident (wheelchair, walker, cane, etc.) _____

If more space is needed, attach a signed and dated sheet and check this box .
 (check only if additional sheet is submitted)

Signature of Director of Nursing or Nursing Manager _____

Title _____ Date _____

For Your Protection State Insurance Laws require the following to appear on this form:
Any Person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in State prison.