PO Box 10811
Clearwater, Florida 33757-8811
Customer Service: 1-877-822-0582
Fax: 1-727-373-4540

LIMITED LONG TERM CARE CLAIM FORM

Section I – To be completed by the Claimant or Legal Representative.
Please print all information and attach any appropriate supporting documentation.

Claimant Name: ______________________________ Policy #: ____________

Address: ______________________ City: __________ State: _____ Zip Code: __________

Date of Birth: __________ Social Security #: ______________ Phone #: ______________

Closest Relative or Power of Attorney Name: ______________________ Phone: ____________

Address: ______________________ City: __________ State: _____ Zip Code: __________

Describe sickness or injury: ______________________________________

If injury, how and when did it happen? ______________________________

If sickness, the date symptoms were first noticed: ______________ Date of first treatment: __________

Attending Physician Name: ______________________________ Phone: ____________

Address: ______________________ City: __________ State: _____ Zip Code: __________

Was a hospital stay needed?: ☐ Yes ☐ No If yes, Admit Date: __________ Discharge Date: __________

If Yes, Facility Name: ______________________________ Phone: ____________

Address: ______________________ City: __________ State: _____ Zip Code: __________

TYPE OF CARE

- ☐ Nursing Home Facility
- ☐ Assisted Living Facility
- ☐ Hospice Facility
- ☐ Other (specify): ______________________________
- ☐ Home Health Care
- ☐ Adult Day Care
- ☐ Durable Medical Equipment (DME)

Servicing Provider: ______________________________ Phone: ____________

Address: ______________________ City: __________ State: _____ Zip Code: __________

Dates of Confinement: Start: __________ End: __________ Break/Leave of Absence: __________

Signature: ____________________ **Print Name**: ____________________ **Date**: __________

Relationship (if not insured): ____________________ **Telephone**: ____________________

LIMITED LONG TERM CARE CLAIM FORM (continued)

Claimant / Patient Name: ____ Policy #: ______________________

Section II – To be completed by the Servicing Provider.
Please print all information and attach all appropriate supporting documentation.

Servicing Provider: ____ Phone: __________________

Address: ____ City: ________________ State: _____ Zip Code: __________

Admit Date: _______________ Discharge Date: _______________ Breaks/Leave of Absence: _____________________

Admitting Diagnosis): ____

Please indicate the patient's functional status for each Activity of Daily Living listed, by checking the appropriate box:

Activity of Daily Living	Independent	Requires hands on assistance	Requires standby assistance
Eating			
Toileting			
Transferring			
Bathing			
Continence			
Dressing			

Please Note – If the servicing provider is a Home Health Care Agency: Please attach a copy of the Caregiver's license, the Home Health Care Agency license, the Physician's Plan of Care, the RN Assessment, and the Caregiver's daily record of services provided for all dates of service.

Signature: ____ **Title**: ____

Printed Name: _______________________________ **Date**: ______________________ **Taxpayer ID#**: _______________

LIMITED LONG TERM CARE CLAIM FORM (continued)

Claimant / Patient Name: ______________________________ Policy #: ________________

Section III – To be completed by the Attending Physician. Please print all information.

Illness or Injury Diagnosis: ______________________________ ICD 10 Codes: ________ ________ ________
Primary Secondary

If Illness, date symptoms first appeared: ____________________ If injury, date of accident: ____________________

Was a hospital stay needed?: ☐ Yes ☐ No If yes, Admit Date: ______________ Discharge Date: ________________

If yes, Facility: ____
Name Address Phone

Date first consulted for this condition: ____________________ Was the patient referred to you?: ☐ Yes ☐ No

If yes, referring Physician: ____
Name Address Phone

Has the patient ever had the same or similar condition?: ☐ Yes ☐ No If yes, prior treatment date(s): ________________

Please indicate the patient's functional status for each Activity of Daily Living listed, by checking the appropriate box:

Activity of Daily Living	Independent	Requires hands on assistance	Requires standby assistance
Eating			
Toileting			
Transferring			
Bathing			
Continence			
Dressing			

State the Medical Necessity that requires the patient to be confined: ____

Is the dependency in functional status due to an organic mental impairment (i.e. Alzheimer's Disease)?: ☐ Yes ☐ No
If yes, give evidence of rational used in making diagnosis (i.e. history, exams, testing, etc): ________________________
____

If Nursing Home confinement is recommended, can the patient be maintained on an Alternate Plan of Care, in lieu of confinement?:
☐ Yes ☐ No If Yes, specify requirements: ____
____

Prognosis and Goals (check appropriate box):
☐ Improvement in functional status expected – less than 3 months
☐ Improvement in functional status expected – 3-6 months
☐ No change in functional status expected
☐ Deterioration in functional status expected – 3-6 months
☐ Deterioration in functional status expected – 6-12 months

Recommended plan of care to improve or maintain current functional status (include any treatments or therapies prescribed, and expected duration): ____
____

Physician Signature: ______________________________ **Printed**: ______________________________

Address: ______________________________ **City**: ______________ **State**: _____ **Zip Code**: ________

Date Signed: ____________________ **Phone**: ____________________ **Taxpayer ID#**: ________________