Medico® Insurance Company
A Wellabe® Company

PO Box 10386
Des Moines, IA 50306
Toll-Free: 800-228-6080
Claims Fax: 402-938-9459

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 ☐ Yes ☐ No

    Reason_____

    Left on _____ Returned on _____ Bed Hold Charge ☐ Yes ☐ No

    Reason_____

    Left on _____ Returned on _____ Bed Hold Charge ☐ Yes ☐ 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
☐ **Skilled**	/ /	/ /	☐ **Independent Living**	/ /	/ /
☐ **Intermediate**	/ /	/ /	☐ **Retirement Facility**	/ /	/ /
☐ **Assisted Living**	/ /	/ /	☐ **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	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐
Continence Bladder/Bowel	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐

*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.