Short Term Care Attending Physician's Statement

Administered By:

Bankers Fidelity Life Insurance Company

4370 Peachtree Road Atlanta, Georgia 30319 1-800-241-1439; Local 404-266-5600 **Claims Department**

Short-Term Care Services Div. P.O. Box 105652

Atlanta, Georgia 30348-5652 1-866-458-7499; Local 404-266-5720

BOTH SIDES MUST BE COMPLETED BEFORE SUBMITTING

PATIENT'S NAME	DATE OF MONTH DAY		SEX	POLICY NUMBER		
			☐ Male ☐ Female			
PATIENT'S ADDRESS (Street/City/State/Zip)		TEL	EPHONE NO	SOCIAL SECURITY NUMBER		
		()				
Current Patient Location:		•				
☐ Custodial Care Facility ☐ Retirement Facility	 ☐ Nursing Facility ☐ Retirement Facility/Independent Living Unit ☐ Other, Specify: 					
If Currently in a facility: Admission Date:	f Currently in a facility: Admission Date: Probable Discharge Date:					
2. Principal Diagnosis relative to incapacity:						
ICD Code: Date Diagnosed: _			Recurring Condit	ion? 🗖 Yes 🗖 No		
3. Other conditions requiring care:						
ICD Code(s): Date Diagnosed: _		Recurring Condition? Yes No				
4. Has patient been confined in a hospital or nursing facility within the past 5 years?						
Address:						
Confinement Dates: FromToTo	Reas	on for confine	ment?			
If "Yes," give evidence of rationale used in making diagnosis (previous treatment).			Ç.			
6. Is patient competent to endorse checks or drafts and direct the use of proceeds thereof?						
7. GIVE THE CURRENT LEVEL OF PATIENT'S FUNCTIONING. ALSO SPECIFY THE DATE OF THIS LEVEL OF FUNCTIONING BEGAN. INDICATE APPROPRIATE NUMBER OF LEVEL. BATHING/TOILETING LEVEL 1. Independent-may use assistive devices (e.g., commode, grab bars); requires no human assistance. 2. May require human assistance on an intermittent basis or with minor parts of bathing/toileting. 3. Is unable to bathe/toilet without substantial assistance from another person.						
LEVEL Date:						
DRESSING LEVEL 1. Independent-requires no human assistance. 2. May require human assistance on an intermittent basis 3. Is unable to dress without substantial assistance from a		of dressing.				

PLEASE COMPLETE BACK SECTION

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 CONTINENCE LEVEL Independent-requires no human assistance or supervision; controls urination and be equipment (e.g.; bedpan). May require human assistance on an intermittent basis for occasional "accidents."			
LEVEL Date:			
TRANSFERRING LEVEL 1. Independent-may use assistive device (e.g., trapeze, railings, walker). 2. Requires physical support on an intermittent basis for difficult maneuvers only (e.g., 3. Is unable to transfer without substantial assistance from another person. LEVEL Date:	toilet, sofa).		
EATING LEVEL 1. Independent-requires no human assistance. 2. May require human assistance on an intermittent basis or with minor parts of eating 3. Is unable to eat without substantial assistance from another person. LEVEL Date:			
8. If in an institution as a practical matter, could patient be cared for under Home Care?			Yes No
Recommended Program of Care (include any treatments or therapies prescribed, include functional status:	ing expected duration)	to improve or	maintain current
 Prognosis and Goals (indicate appropriate number) I.Improvement in functional status expected - less than 3 months. Improvement in functional status expected - 3-6 months. Octange in functional status expected. Deterioration in functional status expected - 3-6 months. Deterioration in functional status expected - 6-12 months. 			
Number of Prognosis/Goal			
Attending Physician Signature Print Name	Degree	Da	ate
Street Address	City or Town	State	Zip Code

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Tax ID Number

Telephone