Short Term Care
Nursing Facility Claim Form

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

TO BE COMPLETED BY THE NURSING CARE FACILITY ADMINISTRATOR OR DIRECTOR OF NURSING AND MAILED TO SHORT TERM CARE SERVICES AT ABOVE ADDRESS

PATIENT'S NAME	DATE OF BIRTH MO. DAY YR.	SEX	SOCIAL SECURITY NUMBER	POLICY NUMBER
		❒ Male ❒ Female		

NAME OF NURSING CARE FACILITY	Phone Number ( )
FACILITY ADDRESS: (Street, City, State, Zip Code)	Tax ID Number

1. Is the Nursing Care Facility licensed by the state as (check all that apply)
   ❒ Skilled Nursing Facility ❒ Intermediate Care Facility ❒ Custodial Care Facility ❒ Assisted Living Facility
   ❒ Alzheimer's Treatment ❒ Personal Care ❒ Congregate Care Facility ❒ Independent Living
   ❒ Continuing Care Retirement ❒ Multiple Care Retirement Facility ❒ Other (Specify) _____
   Is the facility Medicare certified? ..... ❒ Yes ❒ No
   Owner Type: ❒ Private, for Profit ❒ Private, Non-Profit ❒ Public Corp. ❒ Government Owned

2. Staff: Check all that apply
   ❒ Physicians ❒ LPN's ❒ Nurses Aids ❒ Activities Coordinators
   ❒ RNs ❒ Dieticians ❒ Physical Therapists ❒ Occupational Therapist
   ❒ Social Workers (MSW) ❒ Other, Specify: _____

3. Do you have a review plan for all patients? ..... ❒ Yes ❒ No

4. Is Patient competent? ..... ❒ Yes ❒ No
   If "No," give name, address and phone number and relationship to patient or person handling financial affairs:
   Name: _____ Relationship: _____
   Address: _____ Phone Number: ( ) _____

5. Date Admitted: _____ Date Discharged: _____
   Dates of all prior confinements: _____

6. Admitting Diagnosis: _____ ICD Code: _____ Date Diagnosed: _____
   Secondary Diagnosis: _____ ICD Code: _____ Date Diagnosed: _____
   Principal Diagnosis relative to functional incapacity: _____

7. Name of Primary Physician: _____ Phone Number: ( ) _____
   Address: _____

8. Does patient require substantial supervision to protect him/her from threats to health and safety due to severe cognitive impairment? ..... ❒ Yes ❒ No
   Comments: _____
   _____
   _____
   _____

PLEASE COMPLETE BACK SECTION

9. Check appropriate box to describe the level of assistance provided to the patient. Also specify frequency, as applicable.

BATHING/TOILETING	YES	NO	FREQUENCY
● Independent-may use assistive devices (e.g., commode, grab bars); requires no human assistance.	❒	❒	_____
● May require human assistance on an intermittent basis or with minor parts of bathing.	❒	❒	_____
● Is unable to bathe without substantial assistance from another person.	❒	❒	_____
DRESSING			
● Independent-requires no human assistance	❒	❒	_____
● May require human assistance on an intermittent basis or with minor parts of bathing.	❒	❒	_____
● Is unable to bathe without substantial assistance from another person.	❒	❒	_____
CONTINENCE			
● Independent-requires no human assistance; may use assistance or supervision; controls urination and movement completely by self; may use assistive equipment (e.g., bedpan).	❒	❒	_____
● May require human assistance on an intermittent basis for occasional "accidents."	❒	❒	_____
● Requires constant supervision and substantial assistance from another person with bowel and bladder control including appliances (e.g., colostomy, urinary catheter).	❒	❒	_____
● Incontinent of bowel and bladder.	❒	❒	_____
TRANSFERRING			
● Independent-may use assistive device (e.g., trapeze, railings, walker)	❒	❒	_____
● Requires physical support on an intermittent basis for difficult maneuvers only (e.g., toilet. sofa)	❒	❒	_____
● Is unable to transfer without substantial assistance from another person.	❒	❒	_____
EATING			
● Independent-requires no human assistance	❒	❒	_____
● May require human assistance on an intermittent basis or with minor parts of eating (e.g., cutting foods).	❒	❒	_____
● Is unable to eat without substantial assistance from another person.	❒	❒	_____

10. Details and Remarks: Please elaborate on the care and assistance provided the patient for each item marked "Yes" in question 9. above. If applicable, specify the type of therapy administered to patient.

11. I certify that the patient received:

❒ Skilled Care	From: _____	To: _____
❒ Intermediate Care	From: _____	To: _____
❒ Cutodial/Personal Care	From: _____	To: _____
If applicable, indicate days covered by Medicare:	From: _____	To: _____

12. Indicare dates of hospitalization and/or bedhold, LOA days: From: _____ To: _____

Completed By Signature	Print Name	Position/Title	Date
_____	_____	_____	_____