

**LONG TERM CARE CLAIM FORM**

Individual Policy Benefits Dept.  
P O Box 2000  
Lancaster, SC 29721-2000  
(877) 378-1505

**KANAWHA**  
INSURANCE COMPANY

POLICY NO \_\_\_\_\_

My Claim Is For:  Nursing Home Benefits  Hospice Benefits  Bed Reservation Benefits  Adult Day Care Benefits  
 Home Health Care Benefits (If Provided By Policy)  Homemaker Benefits (If Provided By Policy)  
 Alternative Plan Of Care Benefits (If Provided By Policy)  Assisted Living Care Facility Benefits (If Provided by Policy)  
Please contact your agent or Kanawha's Home Office if you wish to request this benefit.

**INSTRUCTIONS FOR FILING A CLAIM**

1. Please complete the front side of this form.
2. Have your doctor complete Part 2 on the back of this form.  
**The following sections are to be completed for each item for which you are making a claim.**
3. Have the nursing home, hospice or other covered facility's director complete Part 3.
4. Have the home health care director complete Part 4.
5. Please send us the completed form along with bills for services covered by your policy.

**PART 1 INSURED PERSON'S STATEMENT**

Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's Address \_\_\_\_\_  
Street or P.O. Box Apt. No. City/State Zip

Code \_\_\_\_\_

The above address is my  Personal Residence or  Nursing Home or Other Facility

Insured's Telephone Number ( \_\_\_\_ ) \_\_\_\_\_ This is my  Home Telephone or  Contact Telephone

Person Holding  Power of Attorney or  Guardianship \_\_\_\_\_  
(Name)

Address \_\_\_\_\_ Daytime Telephone ( \_\_\_\_ ) \_\_\_\_\_  
Street or P.O. Box Apt. No. City/State Zip Code

**INSURED'S STATEMENT REGARDING CLAIM**

Cause of Claim  Illness  Injury Onset Date \_\_\_\_\_ First Treatment \_\_\_\_\_

Nature of Illness or Injury \_\_\_\_\_

Physician or Practitioner \_\_\_\_\_ Date First Seen \_\_\_\_\_

Address \_\_\_\_\_ Telephone ( \_\_\_\_ ) \_\_\_\_\_

Nursing Facility \_\_\_\_\_ City/State \_\_\_\_\_

Telephone ( \_\_\_\_ ) \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Hospice \_\_\_\_\_ City/State \_\_\_\_\_

Telephone ( \_\_\_\_ ) \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Home Health Care Agency \_\_\_\_\_ City/State \_\_\_\_\_

Telephone ( \_\_\_\_ ) \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to prosecution and punishment for insurance fraud.**

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize any physician, practitioner, hospital, nursing facility, assisted living care facility, hospice, home health care agency, pharmacy, insurance organization, consumer reporting agency, employer, or other person or entity possessing any medical information about me to release all information to Kanawha Insurance Company. This includes, but is not limited to, any drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy of this authorization shall be as valid as the original. The authorization shall be valid for one year from the date signed.

Date \_\_\_\_\_ Signature of Insured \_\_\_\_\_

Date \_\_\_\_\_ Signature Of Person Signing For Insured \_\_\_\_\_ Relationship  Attorney-In-Fact  
 Guardian  
 Other

If you are submitting claim as attorney-in-fact or guardian, please attach a certified copy of the power of attorney or letters of guardianship with the first claim submitted.

**PART 2****ATTENDING PHYSICIAN'S STATEMENT**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

ICD Diagnosis and Concurrent Conditions (If diagnosis code other than ICD used, give name.) \_\_\_\_\_

**Activities of Daily Living** — Please indicate areas of daily living with which the patient requires assistance.*Bathing* — means washing, including a sponge bath, with or without extra equipment.  Yes  No Comment \_\_\_\_\_*Continence* — Maintenance of reasonable bowel/bladder personal hygiene.  Yes  No Comment \_\_\_\_\_*Dressing* — putting on and taking off clothing.  Yes  No Comment \_\_\_\_\_*Feeding* — consuming prepared food with or without adaptive utensils. Does not include preparation and cooking of food.  Yes  No Comment \_\_\_\_\_*Toileting* — means both getting on and off the toilet and maintaining a reasonable level of personal hygiene.  Yes  No Comment \_\_\_\_\_*Transferring* — moving from a bed to a wheelchair or other type of convenience or furniture and returning to bed, as needed.  Yes  No Comment \_\_\_\_\_**Mental Status**Does the patient suffer from a cognitive impairment making him or her unable to think, perceive, reason or remember?  Yes  No Comment \_\_\_\_\_Is the patient mentally competent to understand ordinary business transactions and to receive proceeds of insurance?  Yes  No Comment \_\_\_\_\_**Additional Comments** — Please outline any conditions making long term care medically necessary if not covered above. \_\_\_\_\_**Patient Care Requirements**Nursing Home Confinement?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_Hospice Confinement?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_Adult Day Care?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_Home Health Care?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_Other (Specify)?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_

Physician \_\_\_\_\_ T.I.N. or S.S.N. \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART 3 NURSING, HOSPICE, OR OTHER COVERED FACILITY'S STATEMENT**

(to be completed if benefits are claimed)

Date Admitted \_\_\_\_\_ Date Discharged \_\_\_\_\_ Total Days Confined \_\_\_\_\_

Total days out of facility during above period \_\_\_\_\_ Released To \_\_\_\_\_

Facility Name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Street Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Title \_\_\_\_\_ Telephone ( \_\_\_\_ ) \_\_\_\_\_

Date \_\_\_\_\_

**PART 4 HOME HEALTH CARE AGENCY STATEMENT**

(to be completed if your policy provides these benefits and you are making a claim)

Days of Home Health Care provided \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Days of Homemaker \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Benefits Provided \_\_\_\_\_ Service Provided \_\_\_\_\_

Care Provided  Assistance with bathing, dressing, feeding, toileting or transferring  Shopping Occupational, respiratory, physical and speech therapy  Housekeeping Nursing services requiring the services of a licensed nurse  Transportation Constant supervision because a physician has determined that the patient has a cognitive impairment requiring such supervision  Laundry Cooking

Degree or Title of Person Providing Care \_\_\_\_\_ Days of respite care provided \_\_\_\_\_

Agency \_\_\_\_\_ Telephone ( \_\_\_\_ To \_\_\_\_ ) \_\_\_\_\_

Name \_\_\_\_\_ Street Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Tax I.D. \_\_\_\_\_ State License No. \_\_\_\_\_ Federal Certification No. \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_