

My Claim Is For:	<input type="checkbox"/> Home Health Care Benefits	<input type="checkbox"/> Informal Home Health Care Benefits	<input type="checkbox"/> Adult Day Care Benefits
	<input type="checkbox"/> Respite Care Benefits	<input type="checkbox"/> Homemaker Services Benefits	<input type="checkbox"/> Medical Alert System Benefits
	<input type="checkbox"/> Other (Describe _____ )		

**INSTRUCTIONS FOR FILING A CLAIM**

Please review the policy for details of the exact benefits provided and for definitions of covered Activities of Daily Living (ADL's).

1. Please complete the front side of this form.
2. Have your doctor complete Part 2 on the back of this form.
3. Have the provider of covered service complete Part 3.
4. 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 ( \_\_\_\_\_ ) \_\_\_\_\_

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

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

Adult Day Care Center \_\_\_\_\_ City/State \_\_\_\_\_

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

Other Provider \_\_\_\_\_ 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 home health care or other services medically necessary if not covered above. \_\_\_\_\_

**Patient Care Requirements**

Home Health Care?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_

Informal Home Health Care?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_

Respite Care?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_

Homemaker Services?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_

Other (Specify)?  Yes  No Authorized Duration \_\_\_\_\_ To \_\_\_\_\_

Licensed Health Care Practitioner/Physician \_\_\_\_\_

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

Address \_\_\_\_\_

Signature of Physician/Practitioner \_\_\_\_\_ Date \_\_\_\_\_

**PART 3 STATEMENT OF HOME HEALTH CARE AGENCY OR OTHER COVERED PROVIDER**

(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 \_\_\_\_\_

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

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

Shopping

Housekeeping

Transportation

Laundry

Cooking

Days of respite care provided From \_\_\_\_\_ To \_\_\_\_\_

Degree or Title of Person Providing Care \_\_\_\_\_

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

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

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

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