

Administrative Office:
 17 Church Street
 PO Box 506
 Keene, NH 03431

Employer's/Business Entity's Statement			
1. Name of Employee/Insured Person	2. Social Security No.	3. Date of Birth	
4. Phone No.	5. Group No.	6. Occupation	
7. Employee's/Insured Person's Street Address	8. City	9. State	10. Zip Code
11. Employer/Business Entity	12. Employer/Business Entity Phone No.	13. Duties	
14. Employer's/Business Entity's Street Address	15. City	16. State	17. Zip Code
Signed in (City/State) _____ This _____ Day of (Month/Year) _____			
Name of Company _____		Signature _____	Official Position _____
Claimant's Statement			
<input type="checkbox"/> Home Health <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Assisted Living <input type="checkbox"/> Other _____			
1. Policyholder	2. Policyholder's Social Security No.	3. Policy No.	
4. Patient's Name	5. Patient's Social Security No.	6. Phone No.	
7. Street Address	8. City	9. State	10. Zip Code
11. Type of Residence: <input type="checkbox"/> Home <input type="checkbox"/> Apartment <input type="checkbox"/> Retirement Community <input type="checkbox"/> Other _____			
12. Describe condition for which claim is being made			

13. Name of Attending Physician		14. Phone No.	
15. Street Address	16. City	17. State	18. Zip Code
19. Name of Hospital	20. Date Admitted	21. Date Discharged	
22. Street Address	23. City	24. State	25. Zip Code
Name, address and telephone number of person assisting with claim (if any)			
26. Name	27. Relationship	28. Phone No.	
29. Street Address	30. City	31. State	32. Zip Code
Attach a copy of Legal Instrument. Check One: <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardianship			

Patient or Personal Representative's Signature _____ Date _____

Assessment Form

To be completed by Case Manager, Social Security Worker, Registered Nurse or Physician

1. Patient Name	2. Date of Birth
3. Diagnosis	
1. _____	2. _____
3. _____	4. _____
5. _____	6. _____

4. Was Patient Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No From _____ To _____	5. Was Patient in a Nursing Home Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Period Authorization From _____ To _____	7. Medicare Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No

8. The above listed patient requires care to perform the following Activities of Daily Living or Instrumental Activities of Daily Living.
I= Independent S=Stand-by Assistance at Arm's Length O=Needs Hands-On to Perform

ADL	I	S	O	IADL	I	S	O
a. Bathing				h. Medicine Admin			
b. Dressing				i. Personal Financial			
c. Toileting				j. Prepare/Cook Meals			
d. Continence				k. Use Telephone			
e. Mobility				l. Housework			
f. Transfers				m. Laundry			
g. Feeding/Eating							

9. Cognitive Impairment: Yes No (If "Yes", attached Clinical Test/Documentation)

10. I hereby certify that the above listed patient will be chronically ill for a period of 90 days or more: Yes No

11. Patient Requires: Home Health Care Adult Day Care Hospice Program Respite Care Assisted Living Facility

12. Recommended Services: Nurse Therapist Homemaker Companion Other

13. Total Number of Days Per Week:	14. Number of Hours Per Day:	15. Where is care being provided? <input type="checkbox"/> Home <input type="checkbox"/> Apartment <input type="checkbox"/> Retirement Community <input type="checkbox"/> Facility <input type="checkbox"/> Other
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16. Name of Provider:	17. Tax ID/Social Security No.:	18. Phone No.:
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19. Street Address:	20. City:	21. State:	22. Zip Code:
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23. Type of License: Health Care Agency Care Adult Day Care Hospice Program Other

24. Print Name:	25. Degree:	26. Phone No.:
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27. Street Address:	28. City:	29. State:	30. Zip Code:
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Signature _____ Date _____

- Attach the following documents:
- 1) Plan of Care
 - 2) Itemized Billing Statement
 - 3) Explanation of Medicare Benefit Statements (if Medicare coverage on these services)

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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. **Description of the information that may be used or disclosed:** This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. **Exception: psychotherapy notes require a separate signed authorization.**
4. **The information will be used or disclosed only for the following purpose(s):** The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosers of my health information for purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature _____ Date _____

Patient/Insured's SSN _____ Patient/Insured's Date of Birth _____ Patient/Insured's Phone No. _____

Patient/Insured's Address _____

Personal Representative's (if any) Name/Signature: _____ Personal Representative's Phone No. _____

Personal Representative's (if any) Address _____

Description of Personal Representative's Authority or Relationship to Patient/Insured _____

Policy or Contract Number _____

Claimants should retain a copy of this signed document for their records