National States

c/o Missouri Life and Health Insurance Guaranty Association
2210 Missouri Boulevard
Jefferson City, MO 65109
Phone (573) 634-8455 ◆ Fax (573) 634-8488

Monthly Care Certification
(This form must be completed by facility staff only. Please print clearly.)

Facility Information	Insured Information
Name:	Name:
Phone #:	Policy #:
Fax #:	Diagnosis:
Contact:	Family Contact:
Monthly/Daily Rate:	Contact Phone #

Please attach current billing statement for Dates of Service from: __________ To: ____________
Please do not submit the bill until after month's end.

Care Level: □ Skilled □ Intermediate □ Assisted Living □ Other ____________________

1. Please indicate with a check mark, the level of assistance provided by the facility staff with the following activities:

Activities of Daily Living (ADLs)	Independent	Supervision Required	Standby Assistance Required	Hands-on Assistance Required
Bathing/Showering				
Indoor mobility/walking				
Getting in/out of bed/chair				
Continence care bladder/bowel				
Eating				
Toileting				
Dressing				
Medication				

2. (Cognitively impaired residents only) Was Prompting, Cueing or Supervision provided? Yes _____ No _____

3. Does the resident use any of the following? □ walker □ cane □ wheelchair □ other ________________

4. Please indicate any dates that the resident was out of the facility overnight.

Left	Returned	Reason for Absence (i.e. Hospital leave, vacation, etc.)

5. Was the patient discharged within the last 90 days? Yes ___ No ___ please list reason/date for discharge
____

6. Were any days considered by □ Medicare or □ Medicare Advantage Plan? □ Yes □ No If yes, list Paid-in-Full and coinsurance dates: ____

7. Does the resident receive Medicaid assistance? □ Yes □ No
8. Bed hold charge? □ Yes □ No

This form must be attached for each billing statement submitted.
We will not consider any bill unless this from is completed.

Facility Staff Signature/Title: ______________________________________ Date: ________________________

Facility Tax Identification Number: ______________ Type of Facility: _________________________________