National States

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

PLAN OF CARE

THIS FORM MUST BE COMPLETED BY DOCTOR

Start of Care Date: ____/____/____

Certification Period (12 months): From ____/____/____ To ____/____/____

Patient's Name: Policy #

Address: ________________________ Phone: ________________________

________________________ Date of Birth: ____/____/____

Sex: ☐ Male ☐ Female

Primary Diagnosis: ________________________

Secondary Diagnosis: ________________________

Functional Limitations (check applicable items:

Bathing ☐ Dressing ☐ Transfers ☐

Toileting ☐ Continence ☐ Eating ☐

Specify any devices required for transfers or ambulation: ________________________

Home Care Orders (specify # hours per day, # of days per week, # of weeks and type of service ordered):

Anticipated Length of Services: ________________________

PHYSICIAN NAME (please print): ________________________

Address: ________________________

________________________ Phone: ________________________

Signature: ________________________ Date: ________________________