Standard Life And Casualty Insurance Company
ATTN: Claims Department
PO Box 510690
Salt Lake City, UT 84151-0690
Fax: (801) 538-0392

PHYSICIAN'S HOME HEALTH CARE CERTIFICATION

1. Certification Period From:			To:
2. Patient's Name and Address			5. Physician's Name and Address
3. Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female			
4. Policy No.			6. Physician's Tax ID No.
7. ICD-9-CM	Principal Diagnosis	Initial Diag. Date	9. Hospital Confinement for which subsequent Home Health Care is required. A. From: To: B. Name of hospital and address:
8. ICD-9-CM	Other Pertinent Diagnoses	Initial Diag. Date	

10. Can the patient perform any of the following Activities of Daily Living (ADLs) without the assistance of another person?

	YES	NO	
A.	☐	☐	Bathing (getting in and out of the bathtub or shower, utilizing normal bathroom facilities that have been equipped with railings and steps
B.	☐	☐	Dressing (tying shoes, buttoning buttons or clasps)
C.	☐	☐	Eating (consuming food or drink or utilizing utensils, appropriate for the patient's physical condition and which are placed within reach)
D.	☐	☐	Toileting (maintaining adequate bathroom hygiene and toilet habits)
E.	☐	☐	Transferring to or from bed or chair
	If any of the above are answered "NO", please furnish test results.		

11. Does the patient require continuous supervision & assistance due to a Cognitive Impairment (a deficiency in the ability to think, perceive, reason, and/or remember, which has been evaluated and measured through clinical evidence and standardized tests)? ☐ YES ☐ NO ***If "YES", please furnish test results.***

12. Home health services performed.

☐ Skilled Nursing (RN)	☐ Speech Pathology	☐ Enterostomal Therapy
☐ General Nursing (LPN/LVN)	☐ Occupational Therapy	☐ Respiration Therapy
☐ Physical Therapy	☐ Chemo Specialist Services	☐ Medical Social Services

☐ Home Health Care Aide (any individual, other than a member of the patient's immediate family, working under the supervision of an RN, who is qualified, by training and experience, to provide assistance with the Activities of Daily Living listed in 10 above and has been certified by the appropriate regulatory authority).

☐ Other (specify)

_____

13. Other Remarks:	
14. I ☐ certify ☐ recertify that the above statements are true and correct and are based on standard medical tests I have performed and that the above home health services were/are required during the period of certification.	
15. Certifying Physician's Signature	Date Signed

Important Information

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review. Failure to complete all sections may result in a delay in processing this claim.

For information or to check claim status, call 1-800-327-0695.