



tel 800.362.0700  
fax 610.965.6962  
www.penn treaty.com

## FACILITY CERTIFICATION OF CARE FOR INITIAL CLAIM

*Please print clearly using blue or black ink*

### Resident Identification

Name \_\_\_\_\_ Policy # \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Part 1: Facility Instructions *Please complete this form and attach the following information:*

- ☐ All facility health interviews or nursing assessments
- ☐ Copy of all state licenses held by the facility
- ☐ Resident's agreement (applies to assisted living facility)
- ☐ Itemized bill
- ☐ Medicare EOB's (if applicable)

*This form must be completed in full by the Director of Nursing/Charge Nurse.  
A benefit determination cannot be made until we receive all information requested.  
Please be sure to sign and date this form below. You may fax all forms to 610-965-6962.*

### Part 2: Facility Eligibility Information

1. Facility name \_\_\_\_\_
2. Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Telephone ( \_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_ ) \_\_\_\_\_ E-mail \_\_\_\_\_
4. Taxpayer identification # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_
5. Facility type: ☐ nursing ☐ assisted living ☐ independent living ☐ personal care  
☐ continuing care and residential community ☐ other (explain) \_\_\_\_\_
6. Level(s) of care (check all that are available): ☐ skilled ☐ intermediate ☐ custodial  
☐ assisted living ☐ secured unit ☐ independent
7. Maintain medical and care records? ☐ yes ☐ no
8. Number of beds \_\_\_\_\_

**(continued)**

Penn Treaty Network America Insurance Company (In Rehabilitation)  
(Penn Treaty Network America Life Insurance Company in California)  
American Network Insurance Company (In Rehabilitation)

ATTN Claims Department :: PO Box 7066 :: Allentown, PA 18105-7066

Name \_\_\_\_\_ Policy # \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*All questions must be answered for the resident to be considered for benefits.*

### Part 3: Resident Information

1. Initial admission date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Admitted from: ☐ residence ☐ hospital ☐ other \_\_\_\_\_

2. Discharge date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Discharged to: ☐ residence ☐ hospital ☐ other \_\_\_\_\_

3. Any out-of-facility dates? ☐ no ☐ yes *If yes, complete the following:*

left \_\_\_\_ / \_\_\_\_ / \_\_\_\_ returned \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ☐ to hospital ☐ other \_\_\_\_\_

left \_\_\_\_ / \_\_\_\_ / \_\_\_\_ returned \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ☐ to hospital ☐ other \_\_\_\_\_

4. Bed hold charges? ☐ yes ☐ no If yes, amount charged per day \$ \_\_\_\_\_

5. Admitting diagnosis \_\_\_\_\_

6. Current diagnosis \_\_\_\_\_

7. Admitting physician name \_\_\_\_\_ Telephone ( \_\_\_\_ ) \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

8. Is the stay Medicare approved? ☐ no ☐ yes

If yes, list dates paid in full \_\_\_\_ / \_\_\_\_ / \_\_\_\_ through \_\_\_\_ / \_\_\_\_ / \_\_\_\_

List co-pay dates \_\_\_\_ / \_\_\_\_ / \_\_\_\_ through \_\_\_\_ / \_\_\_\_ / \_\_\_\_

9. Resident's care level: *check all that apply including the "From" and "To" dates*

|                                               | From | To | From | To |
|-----------------------------------------------|------|----|------|----|
| <input type="checkbox"/> Skilled              |      |    |      |    |
| <input type="checkbox"/> Intermediate         |      |    |      |    |
| <input type="checkbox"/> Assisted Living      |      |    |      |    |
| <input type="checkbox"/> Independent Living   |      |    |      |    |
| <input type="checkbox"/> Retirement Community |      |    |      |    |
| <input type="checkbox"/> Other (explain)      |      |    |      |    |

For your protection, state insurance laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Please refer to the accompanying page for mandated state-specific fraud language.

11. Print name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

For your protection, certain states require specific mandated fraud language to be included on all claim forms. Other states permit the use of a more generalized fraud statement.

**California**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia**

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Maryland**

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Oregon**

Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

**Pennsylvania**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**All Other States Not Listed Above**

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim for payment of a loss or benefit containing any false, incomplete or misleading information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act and may be prosecuted under state law. Penalties may include imprisonment, fines, denial of insurance or insurance benefits, and civil damages. Insurance fraud is considered a felony offense in Delaware, Florida (third degree), Idaho, Indiana and Oklahoma.