



Individual Long Term Care Alternate Plan of Care Request Form

- INSTRUCTIONS:**
1. You must complete this form in full.
 2. Print or type all information except where a signature is required
 3. Your Physician must review and complete the certification section below
 4. Return the completed form to: CNA Insurance Companies,
P.O. Box 64912, St. Paul, MN 55164-0912

Name of Insured: _____

Policy Number of Insured: _____ Social Security Number _____

1. Primary Diagnosis: _____ Date of Diagnosis: _____

2. Please state the reason for your Alternate Plan of Care Request (attach additional sheets as necessary)

3. Please indicate what activities the caregiver will be assisting you with and the level of assistance you require.

	Independent	Supervision / Cueing	Physical Assistance	Totally Dependent
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Is continuous supervision required due to a cognitive impairment? Yes No

5. Do you receive any type of in home care (formal or informal)? Yes No

6. How many hours per day do you receive assistance? _____

7. How many days per week do you receive assistance? _____

8. From whom do you receive the assistance? _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO OMIT ANY FACTS I KNOW ARE IMPORTANT

Person Submitting the Request _____ Relationship to Insured _____

Signature of Person Submitting the Request _____ Date _____

PHYSICIAN CERTIFICATION

I, Dr. _____ have reviewed the Alternate Plan of Care Request for (Patient) _____. I agree with the care enumerated above and certify the need for care for a six month period beginning (Start Date) _____ through (End Date) _____.

Signature of Physician _____ Date _____

Physician Address: _____

Telephone Number: _____ Fax Number: _____

**AUTHORIZATION FOR USE AND DISCLOSURES OF
PROTECTED HEALTH INFORMATION**
to an Authorized Individual/Personal Representative

I, _____, policy number _____,
hereby authorize the use and disclosure of my protected health information, as it relates to
coverage, billing, and claims administration, or as defined, or as limited to the following:

Continental Casualty Company may release my protected health information as described above
to the following person(s):

Printed Name of Authorized Individual	Phone Number
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Street Address

City	State	Zip Code
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This form is for use and disclosures only. It does not authorize anyone other than me or my legal representative to make any changes to my coverage, billing, or demographic information. I understand that if the person or entity that receives my information is not covered by the federal privacy regulations, my information may be re-disclosed by such person or entity and will then no longer be protected.

This authorization is valid until my coverage ends, unless a specific expiration date or event is specified here: _____. I understand that I may revoke this authorization in writing at any time. I am entitled to make a copy of or request to receive a copy of this authorization.

I understand that I am not required to sign this authorization and that payment or eligibility will not be conditioned upon my choice not to sign. I further understand that my protected health information cannot be disclosed to any unauthorized third party without my signature.

I acknowledge by my signature below that I have read and understand this Authorization, that it accurately reflects my wishes, and that a photocopy, facsimile, or other electronic copy is as valid as the signed original.

Signature of Insured or *Legal Representative	Date
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*If you are signing as a legal representative, describe the scope of your authority to act on the insured's behalf and include a copy of the documentation of your legal authority.

Fax back to us at 1-952-983-5193



Individual Long Term Care Claim Form Authorization to Release Information

Continental Casualty Company,
CNA Plaza, Chicago IL 60685

Administrative Office: CNA Insurance Companies,
P.O. Box 64912 St. Paul, MN 55164-0912

Name of Insured

/ /
Date of Birth

“Information Provider” as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, home and community based provider, affiliated and non-affiliated insurance or reinsuring company, agent, Health Claims Index, credit bureau or other consumer reporting agency, employer or the Veterans Administration

“Information” received from an Information Provider concerning the patient may include information relating to any advice, diagnosis, prognosis, treatment or care of my physical or mental condition, including information about any illness or injury, consultations, prescriptions or treatment, including x-ray plates and hospital records, records of drug or alcohol abuse and treatment, or mental illness (except psychotherapy notes), HIV, and/or financial, consumer report, or any other non-medical information regarding me.

I AUTHORIZE any Information Provider to give Continental Casualty Company (the Company), its legal representatives or its reinsurers, any and all Information regardless of any previous restriction or limitation on disclosure of such Information.

I UNDERSTAND that:

- the Information obtained by use of this Authorization is at my request and will be collected by the Company to evaluate claims for insurance benefits.
- this Authorization shall remain valid for the duration of the claim.
- the Company will condition eligibility for benefits on my signing this Authorization, therefore a decision not to authorize release of information as described in this Authorization may prevent the Company from evaluating or paying the claim.
- I may revoke this Authorization at any time by providing written notice to the Company, except to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation.
- if I exercise my right to revoke this authorization during the duration of the claim, the Company may be prevented from fully evaluating or paying the claim.
- the Company may maintain or have access to personal information acquired separately through any of my previous insurance applications with the Company or its affiliates for insurance even in instances where insurance was not placed. I authorize the Company to use or disclose such information for evaluation of the claim.
- information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.
- I may request to receive a copy of this Authorization and I agree that a photographic copy of this Authorization shall be as valid as the original.

Signature of Insured or Authorized Representative

Date

If signed by Authorized Representative, describe your authority to sign on behalf of the Patient

Street Address

City

State

Zip



Individual Long Term Care Claim Form Claimant's Statement

You must complete this form in full.
Please print or type all information except where signature is required.
Please return the completed form to the insured or authorized representative or
to CNA Insurance Companies, P.O.Box 64912 St Paul, MN 55164-0912

Name of Insured		Date of Birth	Social Security Number	
Street Address		City	State	Zip
Phone Number ()		Policy Number(s)		
Name of closest relative/Power of Attorney (if applicable, please enclose a copy of the legal documents)			Relationship	
Street Address		City	State	Zip
Phone Number: Home		()		
		Work ()		

1. What type of benefits are you filing for?

- Nursing Home / Facility Home Health Care Other

Please provide the reason or condition for which you require care: _____

How long do you anticipate the need for care? _____

2. Were you in the hospital within 30 days prior to receiving Facility or Home Health Care? Yes No

If yes, please give the dates of hospitalization and the name of the hospital where you were a patient.

Date Admitted _____ Date Discharged _____

Hospital Name _____ Hospital Phone Number
()

Address _____

3. Please provide the name and address of your attending / primary physician (if you have more than one, please list the physicians information on the reverse side of this form):

Name _____ Phone Number
()

Address _____

4. Is Medicare or Medicaid providing benefits for any services for which you are filing this claim? Yes No

Please list all other insurance coverage, including Medicare or Medicare HMO.

Insurance Co. Name/Phone #: _____

Insurance Co. Name/Phone #: _____

I have read and understand the penalties imposed by various states for misrepresentation of information.

Signature of Claimant or Authorized Representative _____