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

HOW TO FILE A HOME HEALTH OR NURSING HOME CLAIM

1. Answer all questions on your INSURED'S portion of the form.
2. Sign and date Patient Authorization.
3. Have your doctor complete and sign the physician portion of the form.
4. Attach all bills pertinent to your claim and mail to Missouri Life and Health Insurance Guaranty Association.
5. Attach a copy of the current nursing home/assisted living facility/home health care license.

TO BE COMPLETED BY PHYSICIAN FOR HOME HEALTH AND NURSING HOME CLAIMS ONLY

1. Patient's Name _____ Age _____
2. Patient's Address _____
3. Patient's Phone No. _____ Patient's Email _____
4. Nature of sickness or injury _____
5. Did you order nursing facility placement? _____ Date admitted _____ Prognosis _____
6. Did you order home health care services? _____ Date Care Started _____ Estimated Length of Care _____

Must be recertified every 12 months

Date _____ ***PHYSICIAN'S SIGNATURE*** _____

Address _____ Telephone # ( ) _____

Functional Limitations (check applicable items):

☐ Bathing ☐ Dressing ☐ Transfers ☐ Toileting ☐ Continence ☐ Eating

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TO BE COMPLETED BY INSURED FOR HOME HEALTH AND NURSING HOME CLAIMS ONLY

1. Describe sickness or injury: _____
2. Date accident occurred or illness began: _____
3. Was hospitalization required? _____ If yes, date admitted _____ Date Discharged _____

   Name and address of hospital _____
4. Was nursing facility confinement required? _____ If yes, date admitted _____ Date Discharged _____
5. Was home health care required? _____ If yes, date care started _____ Date Care Ended _____
6. Name(s) and address(es) of physician(s) who prescribed these services _____

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PATIENT AUTHORIZATION (MUST BE COMPLETED)

National States Insurance Company in Liquidation (referred to as National States), its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my (our) claim for health insurance benefits.

Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer and consumer reporting agency or insurance company who possesses information of care, treatment or advice of me or my children may furnish such information to National States or its representative upon presenting this authorization or a photocopy.

This authorization includes information about drugs, alcoholism or mental illness.

This authorization will be valid from the date signed for a period not to exceed the terms of the policy under which claim is being made.
I have read this authorization and know that I, or any person I authorize to act on my behalf, may request a copy of it. I know that I may revoke this authorization at any time by notifying National States in writing of my wish to do so.

Date _____ Policyholder's Signature _____

Policyholder's Name _____ Claimant's Name _____

Policyholder's Email Address _____