Clear Form

Physicians Mutual® Insurance for all of us.®

Physicians Mutual Insurance Company
Claim Services
PO Box 2018
Omaha, NE 68103-2018
Fax: 1-402-633-1020
provider.physiciansmutual.com

Long Term Care Patient Care Flow Sheet

Insured's Name _____ **Claim Number** _____

Caregiver's Information

Caregiver's Name _____ Caregiver's Phone Number (_____) _____

Caregiver's Address _____

Last Four Digits of SS# or CNA/Nurse License Number _____ Caregiver's Date of Birth _____

Date		Indicate AM or PM In	Out	In	Out	Total Hours Worked	Hourly Rate	Amount Charged
	Mon							
	Tues							
	Wed							
	Thu							
	Fri							
	Sat							
	Sun							

Check Number: _____ **(Please attach the front and back of the canceled check when filing this form.)**

Is the caregiver a relative to the insured by blood or marriage? ☐ Yes ☐ No If yes, explain relationship. _____

Was the insured hospitalized this week? ☐ Yes ☐ No If yes, provide the day(s). _____

Caregiver Instructions: Place a check mark in the box each day assistance is provided for the listed activities.

Caregiver Weekly Notes Regarding Activities: Starting Date ____/____/____ **Ending Date** ____/____/____

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Assist with Eating (Excludes meal preparation)	☐	☐	☐	☐	☐	☐	☐
Assist with Bathing/ Showering	☐	☐	☐	☐	☐	☐	☐
Assist with Dressing	☐	☐	☐	☐	☐	☐	☐
Assist with Transferring	☐	☐	☐	☐	☐	☐	☐
Assist with Ambulating	☐	☐	☐	☐	☐	☐	☐
Assist with Toileting	☐	☐	☐	☐	☐	☐	☐
Assist with Pads/ Change Briefs/ Emptying Catheter Bag/ Bed Pan/ Urinal	☐	☐	☐	☐	☐	☐	☐
Assist with Medications, Housekeeping, Meal Prep/ Cleanup, Laundry	☐	☐	☐	☐	☐	☐	☐
Assist with Running Errands/ Food Shopping	☐	☐	☐	☐	☐	☐	☐
Assist with to/ from Doctor/ Medical Appointments	☐	☐	☐	☐	☐	☐	☐
Other (Please specify what and where) _____	☐	☐	☐	☐	☐	☐	☐

For Insured:

I certify that all of the information disclosed on the Patient Care Flow Sheet is correct. Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files a statement of claim containing any false, incomplete or misleading information commits a fraudulent insurance act subject to criminal prosecution and civil penalties and/or guilty of a felony.

X _____ _____

Insured's or Responsible Party's Signature Date

For Caregiver

I certify that all of the information disclosed on the Patient Care Flow Sheet is correct. Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files a statement of claim containing any false, incomplete or misleading information commits a fraudulent insurance act subject to criminal prosecution and civil penalties and/or guilty of a felony.

X _____ _____

Caregiver's Signature Date