Physicians Mutual® Insurance for all of us.®

Physicians Mutual Insurance Company
Claim Services
PO Box 2018
Omaha, NE 68103-2018
1.800.228.9100

Physicians Mutual Plan of Care/Treatment Form

Patient's Name	Date of Birth	Claim Number
	____ Month ____ Day ____ Year	

1a. Primary Diagnosis	**1b.** Secondary Diagnosis
______________________	______________________
Date first treated for this condition? ____ Month ____ Day ____ Year	Date first treated for this condition? ____ Month ____ Day ____ Year

Is cognitive impairment, in any form, causing this need for assistance? ☐ YES ☐ NO

If YES, what is the specific cognitive impairment diagnosis? ______________________

If YES, is it due to alcohol/drug use or a mental/nervous disorder? ☐ YES ☐ NO

For Cognitive Impairment, what amount of supervision (including care from family) do you recommend?

# of hours per day, _____ and # of days per week _____

2. Please check, indicating the highest level of assistance your patient needs with **each** of these activities.

	Eating	Bathing	Dressing	Toileting	Transferring	Continence	Ambulating
Independent	☐	☐	☐	☐	☐	☐	☐
Supervision / Cueing	☐	☐	☐	☐	☐	☐	☐
Standby / Hands-On	☐	☐	☐	☐	☐	☐	☐

3. Where do you recommend the care (including care from family) be provided for your patient?

A. ☐ Assisted Living Facility (ALF) / Personal Care Facility ☐ Skilled Nursing Facility/Nursing Home

☐ Respite Facility ☐ Hospice Facility

Is 24 Hour Care Recommended? ☐ YES ☐ NO

If no, what amount of care do you recommend? # of hours per day, _____ and # of days per week _____

B. ☐ Home Health Care ☐ Adult Day Care/Respite Care ☐ Hospice

What is your recommendation for the total number of hours per day and days per week (including care from family) the patient needs assistance for:

Activities of daily living: # of hours per day, _____ and # of days per week _____

Homemaker Services: # of hours per day, _____ and # of days per week _____

Name of Physician / Licensed Health Care Practitioner ______________________

Address ______________________ City/ State/ ZIP ______________________

Telephone Number ( ) ______________________ Fax Number ( ) ______________________

X ______________________ ______________________

Physician's / Licensed Health Care Practitioner's Signature Date

Please return via Provider Portal at provider.physiciansmutual.com or fax to 1-402-633-1020. If you have any questions, please call us at 1-800-228-9100.