FACILITY QUESTIONNAIRE

Please send completed questionnaire to

HealthSmart Benefit Solutions
PO Box 1014
Charleston, WV 25324-1014
Fax: 806-473-2535

Claimant: _____

Facility Name: _____

About Your Facility:

1. Please provide copies of all licensures/accreditations for your facility (Medicare, State Department of Health, etc.)

2. Please provide your Facility's Tax Identification Number. _____

3. Does your facility have organized facilities to care and treat the residents?

   Yes ☐ No ☐

4. Does the unit where the patient is residing, provide continuous 24-hour nursing services by or under the supervision of an RN or LPN?

   Yes ☐ No ☐

	Hours Per Day	Days Per Week
RN on staff		
RN on call		
LPM on staff		
CNA on duty		
Other:		

5. If aides are on staff, are they state certified / accredited?

   Yes ☐ No ☐

   If not, what type of training is required?

   _____

   _____

   Are copies of their certification / accreditations / course completions on file at your facility and are they available to us?

   Yes ☐ No ☐

Claimant:
DOB:

6. Are any outside agencies/firms utilized to staff your facility? If so, please advise the complete name, address and telephone number of the agencies/firm and what services they perform in your facility.

Yes □ No □

_____

_____

_____

7. If your facility has different levels of care, please advise and explain each level.

_____

_____

_____

_____

8. What types of records are kept?

□ Daily □ Weekly □ Monthly □ Other (explain)

_____

Are they available to us if needed?

Yes □ No □

About the claimant:

1. When was this claimant admitted to your facility and does he/she still reside there? If not, when was the patient discharged and, if known, where was the patient discharged to?

_____

_____

2. Please provide the dates of all bedhold days while the patient was at your facility.

_____

_____

3. Why was this claimant admitted to your facility? Give diagnoses and describe type of care required.

_____

_____

_____

Claimant:
DOB:

4. Is there a certified treatment plan completed and signed by the claimant's attending physician? If so, please submit a copy to us.

Yes □ No □

5. Please provide a copy of your facility's initial patient assessment.

6. Is the confinement in lieu of an acute hospital confinement?

Yes □ No □

7. What is the level of care in which the claimant resides?

_____

8. Please advise the specific services being rendered to this claimant. Include any activities of daily living.

_____

_____

_____

9. What medications have been prescribed?

Medication	Dosage	Diagnosis	Dispensed by: Staff or Claimant (if staff, state professional designation)

(Use a separate sheet of paper if more space is needed)

10. If you are a Medicare Certified facility, have any of the services been billed to Medicare? If so, please provide a copy of the Medicare statement.

Yes □ No □

11. Have any of the services been billed to Medicaid? If so, please provide a copy of the Medicaid statement.

Yes □ No □

Claimant:
DOB:

12. Please advise the complete name, address, and telephone number of any additional insurance policies, such as Long-Term Care, that this claimant is covered under.

_____

_____

Completed by:

_____ _____
Please Print Name Title

_____ _____
Signature Date

Claimant:
DOB: