HOME HEALTH CARE QUESTIONNAIRE

Please send completed questionnaire to

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

Agency Name:

About Your Company:

1. What is the licensure/accreditation of your company? Please enclose a copy.

   _____

2. If you are not a Home Health Care Agency, but you are a Nurse Registry or an Employment Agency, do you keep copies of the licenses/certifications/accreditations of your caregivers?

   Yes ☐ No ☐

3. Do you keep daily care notes for each patient?

   Yes ☐ No ☐

4. Do you have malpractice insurance?

   Yes ☐ No ☐

5. Are your employees bonded?

   Yes ☐ No ☐

Specific to this Claimant:

1. When did the member begin service with you? If no longer in service with you, please advise discharge date.

   _____

   _____

Claimant:
DOB:

2. Please advise the complete name and address where services are/were being rendered.

_____

_____

3. Is/was this care in lieu of a hospital or a skilled nursing home confinement?

Yes □ No □

4. Please provide a copy of the claimant's original "Certification and Treatment Plan", signed by his/her attending physician, along with any updated treatment plans. (This documentation must show the frequency and duration of care.)

5. If you are a Nurse Registry or an Employment Agency, please forward copies of the licenses/certifications/accreditations of all caregivers who rendered services to the patient. If not licensed/certified/accredited, please state training requirements and provide proof of training completion.

_____

_____

6. Please provide a copy of the initial assessment and all subsequent assessments performed on the patient.

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

8. Is another Home Health Care Agency or private home health caregiver rendering any concurrent services? If so, please provide their complete name, address and telephone number.

Yes □ No □

_____

_____

_____

Claimant:
DOB:

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

_____

_____

_____

Completed by:

_____ _____

Please Print Name Title

_____ _____

Signature Date

Claimant:
DOB: