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

Monthly Facility Verification Form

Patient's Name: _____ Date of Birth: _____

Claim Number: _____ Policy Number: _____

Facility Name: _____ Facility Fax Number:_____

Please make a copy of this form to complete at the end of each month and send it with the corresponding bill.

Dates of Service: _____

1. Was the patient in the facility during the dates listed above? ☐ Yes ☐ No
2. Were there any absences during the dates listed above? ☐ Yes ☐ No
   a. What was the reason for the absence?
   _____
   b. Please provide dates absent from the facility:
   _____
   c. Was the patient charged for the days absent? ☐ Yes ☐ No
   d. Did the patient return to the facility under Medicare? ☐ Yes ☐ No
3. Is the patient in the same level of care? ☐ Yes ☐ No
4. Is the patient still in the facility now? ☐ Yes ☐ No

_____
Signature

_____ _____
Title 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.