Clear Form

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 (Month / Day / Year)	Claim Number	Policy Number
	____ ____ ____		

1a. Primary Diagnosis _____

Date first treated for this condition? ____ ____ ____ (Month / Day / Year)

1b. Secondary Diagnosis _____

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. What type of facility care (24/7) do you recommend for your patient?

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

☐ Respite Facility ☐ Hospice Facility

4. If not 24/7 facility care, what type of care below do you recommend for your patient?

☐ Home Health Care ☐ Adult Day Care ☐ Hospice Facility 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 _____

Information below is not to be completed by any staff providing above care/services.

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.