Clear Form

Physicians Mutual® Insurance for all of us.®

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

Long-Term Patient Care Flow Sheet

Insured's Name _____ Claim Number _____ Policy Number _____

Caregiver's Information

Caregiver's Name _____ Caregiver's Phone Number (_____) _____

Caregiver's Address _____

Last Four Digits of SS# or CNA/Nurse License Number _____ Caregiver's Date of Birth _____

Date		Indicate AM or PM In	Out	In	Out	Total Hours Worked	Hourly Rate	Amount Charged
	Mon							
	Tues							
	Wed							
	Thu							
	Fri							
	Sat							
	Sun							

Check Number: _____

Is the caregiver a relative to the insured by blood or marriage? ☐ Yes ☐ No If yes, explain relationship. _____

Was the insured hospitalized this week? ☐ Yes ☐ No If yes, provide the day(s). _____

Caregiver Instructions: Place a check mark in the box each day assistance is provided for the listed activities.

Caregiver Weekly Notes Regarding Activities: Starting Date ____/____/____ Ending Date ____/____/____

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Assist with Eating (Excludes meal preparation)	☐	☐	☐	☐	☐	☐	☐
Assist with Bathing/ Showering	☐	☐	☐	☐	☐	☐	☐
Assist with Dressing	☐	☐	☐	☐	☐	☐	☐
Assist with Transferring	☐	☐	☐	☐	☐	☐	☐
Assist with Ambulating	☐	☐	☐	☐	☐	☐	☐
Assist with Toileting	☐	☐	☐	☐	☐	☐	☐
Assist with Pads/ Change Briefs/ Emptying Catheter Bag/ Bed Pan/ Urinal	☐	☐	☐	☐	☐	☐	☐
Assist with Medications, Housekeeping, Meal Prep/ Cleanup, Laundry	☐	☐	☐	☐	☐	☐	☐
Assist with Running Errands/ Food Shopping	☐	☐	☐	☐	☐	☐	☐
Assist with to/ from Doctor/ Medical Appointments	☐	☐	☐	☐	☐	☐	☐
Other (Please specify what and where) _____	☐	☐	☐	☐	☐	☐	☐

For Insured:

I certify that all of the information disclosed on the Long-Term Patient Care Flow Sheet is correct. Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files a statement of claim containing any false, incomplete or misleading information commits a fraudulent insurance act subject to criminal prosecution and civil penalties and/or guilty of a felony.

X _____ _____

Insured's or Responsible Party's Signature Date

For Caregiver

I certify that all of the information disclosed on the Long-Term Patient Care Flow Sheet is correct. Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files a statement of claim containing any false, incomplete or misleading information commits a fraudulent insurance act subject to criminal prosecution and civil penalties and/or guilty of a felony.

X _____ _____

Caregiver's Signature Date