INDEPENDENT CAREGIVER ITEMIZED BILL & DAILY VISIT NOTE FORM

BANKERS
LIFE AND CASUALTY COMPANY

CLAIMANT NAME (PRINT): _____ POLICY NUMBER: _____

CAREGIVER'S NAME (PRINT): _____ Check where services are rendered: ☐ Home ☐ Facility

Caregiver is a (check one): ☐ Certified Home Health Aide ☐ C.N.A. ☐ RN ☐ LPN/LVN ☐ Personal Care Attendant (PCA) ☐ Companion/Homemaker

The hired caregiver must complete this form in ink every visit. Return originals only. Retain a copy for your records. Under each date of service, please check services provided.

REQUIRED	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
DATE (Month/Day/Year)								
Arrival Time: AM/PM								
Departure Time: AM/PM								**Totals**
Total Hours Worked:								
Hourly Rate:	$	$	$	$	$	$	$	
Total Charge:	$	$	$	$	$	$	$	$
Services Provided:								
Ambulating Inside-Physically Assisted								
Ambulating Inside-Standby Assist								
Bathing-Physically Assisted								
Bathing-Standby Assist								
Bathing-Verbal Cue or reminder								
Dressing-Physically Assisted								
Dressing -Standby Assist								
Dressing- Verbal Cue or Reminder								
Eating-Spoon Fed or Tube Fed								
Eating-Verbal Cue or Reminder								
Transfer out of bed/chair-Physically Assist								
Transfer out of bed/chair-Standby Assist								
Transfer out bed/chair-Verbal Cue or Reminder								
Toileting-Physically Assisted								
Toileting-Standby Assist								
Toileting-Verbal Cue or Reminder								
Incontinent of bowel/bladder-Physically Assisted								
Assistance with Colostomy/Catheter Care								
Provided Continual Supervision due to Cognitive Impairment: **Cannot be left alone**								
Provided Continual Supervision due to a Physical Functional Incapacity: **Cannot be left alone**								
Companion Services								
Homemaking/Housekeeping-laundry, meal prep, dust, wash dishes, other:								

Was your client hospitalized or in a facility this week? ☐ Yes ☐ No

We cannot process this claim until this form is fully completed. Both signatures are required. The form should not be signed until the work week has concluded and all weekly services are recorded.

I hereby certify that the information provided above is a complete and accurate representation of the care provided and received.

Caregiver Signature: _____ Date: _____/_____/_____

Claimant or Legal Representative Signature: _____ Date: _____/_____/_____

Fraud Notice: Any person who, with an intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties. Please refer to enclosed state variation sheet for state specific wording regarding this fraud notice.