Senior Health Insurance Company of Pennsylvania

CONTINUED MONTHLY RESIDENCE FORM

Instructions:

- *The Continued Monthly Residence (CMR) form is a required part of the monthly claim submission and must be completed thoroughly by facility staff.*
- *Ensure copies of current BLANK CMR forms are maintained by the facility.*
- *Complete a form for each month, on or after the last day of the month, after the services have been provided. (Example: Facility charges from June 1st-June 30th should not be submitted prior to July 1st).*
- *Submit with a copy of the facility's invoice reflecting room and board charges for the service period.*
- *Incomplete forms and photocopies of a prior month's completed CMR form will be considered ineligible and may delay the reimbursement process.*

Please complete the form and return monthly via fax to 952-983-5256 (preferred), or mail to: Senior Health Insurance Company of Pennsylvania, P.O. Box 64913, St. Paul, MN 55164.

Facility Name: _____ Resident Name: _____
Facility Address: _____ Resident Policy #: _____
Facility City/State: _____ Resident Room #: _____
Facility Phone #: _____ Resident Move-In Date: _____
Facility Fax #: _____ Month of Service: From _____ Through_____

1. **Has the resident remained in the same room/apartment for the entire month?** ❑ Yes ❑ No
   If no, provide prior room/apartment #: _____

2. **Select the level of care that describes the resident's current room, unit or apartment:**
   - ❑ Alzheimer's/Dementia unit (secured)
   - ❑ Alzheimer's/Dementia unit (non-secured)
   - ❑ Assisted living unit (secured)
   - ❑ Assisted living unit (non-secured)
   - ❑ Independent living apartment or unit
   - ❑ Skilled Nursing Facility
   - ❑ Intermediate Care Facility

3. **At any time during this service period, was the resident away from the facility overnight for any reason?** ❑ Yes ❑ No
   If yes, provide dates: Departure Date: _____ Return Date: _____
   Provide reason for absence: _____
   If absence was a hospital stay, provide dates: Admission Date: _____ Discharge Date: _____

4. **Is Medicare, Medicaid/MediCal or any other insurance providing benefits for expenses incurred during this service period?**
   ❑ No
   ❑ Yes, **Medicare**, provide a copy of the Explanation of Medicare Benefits (EOMB); UB-04 form or other proof of remittance by Medicare or Medicare intermediary; or provide dates of 100% coverage/coinsurance coverage:
   _____
   ❑ Yes, **Medicaid/MediCal**, provide the contact information for Medicaid/MediCal Case Worker:
   Case Worker Name: _____
   Phone Number: _____ Fax Number: _____
   Medicaid/MediCal office: _____
   ❑ Yes, **other insurance coverage** information:
   Insurer Name: _____ Policy Number: _____
   Insurer Address: _____ Phone Number: _____

By signing below, I declare that all of the answers given are complete and true to the best of my knowledge and belief.

_____

Print Name *Title* *Phone Number*

_____

Signature *Date*