Provider:	
Provider ID:	

To

Attention:

Fax Number:

Re:

From

Claims Credentialing Coordinator

The attached provider verification form contains the required questions needed to help us evaluate your eligibility as a provider for coverage under our client's long-term care insurance plan.

You can complete this request the following ways:

1- Online via your ProviderHub account at providerhub.ltcg.com.
2- Complete and fax the attached form to 877-769-8203 or by emailing it to providereligibilityes@illumifin.com.
3- Complete and return the form by mail to Senior Health Insurance Company of Pennsylvania (In Rehabilitation), P.O. Box 64913, St. Paul, MN 55164.

If you have not yet registered for a ProviderHub account, email us at providerdirectory@illumifin.com or call us at 888-396-5824 with your facility name and address to start your registration today!

Please complete a separate form if the Assisted Living and Memory Care Staffing differs.

In addition to the attached questions, please also provide the following:

Current Licensure (If your state is currently in the process of renewing your license and you have not received your new license, please send in the appropriate letter from the state.) If your state does not issue a state license, please provide your professional liability insurance and business license.

If this information is not received in a timely manner, we may be unable to approve any current or future claims for benefits for individuals for whom you are providing services.

Sincerely,

Claims Credentialling Coordinator

Provider:	
Provider ID:	

Please complete the below table with the name of the memory care unit or dedicated facility, the number of beds, and the room numbers that range within the unit or facility.

Facility Name	# of beds licensed for	Room numbers associated with each level of care (can be a range)

What medical records are maintained by the facility?	☐ ADL/Personal Care Assistance ☐ Care plan, service plan or nursing assessment ☐ Incidents ☐ Vital Checks ☐ None ☐ Other:
Does the facility accept, and nursing staff operate under the physician's orders?	☐ Yes ☐ No
STAFFING	
Do you have an RN on-site? How many hours is the RN on-site?	☐ Yes ☐ No ___ Days per week / ____Hours per day
Do you have an RN on-call 24/7?	☐ Yes ☐ No
How is your RN employed?	☐ Contractor (does not include agency staff) ☐ Employee ☐ Other
In what capacity do the facility RNs operate (check all that apply)?	☐ Administrative ☐ Medical Records Oversight ☐ Provides Nursing Care ☐ Other:
Do you have an LPN/LVN on-site? How many hours is the LPN/LVN on-sit?	☐ Yes ☐ No ___ Days per week / ___ Hours per day
Do you have an LPN/LVN on-call 24/7?	☐ Yes ☐ No

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How is your LPN/LVN employed?	☐ Contractor (does not include agency staff) ☐ Employee ☐ Other:
In what capacity do the facility LPNs/LVNs operate (check all that apply)?	☐ Administrative ☐ Medical Records Oversight ☐ Provides Nursing Care ☐ Other:
Do you have a CNA on-site?	☐ Yes ☐ No
Do you have a Med Tech on-site?	☐ Yes ☐ No
Do you have a CMA on-site?	☐ Yes ☐ No
Are employees trained and ready to respond on-site 24/7 (includes CNA, CMA and licensed nurse)?	☐ Yes ☐ No
If yes, are employees up, awake and ready to respond 24 hours per day?	☐ Yes ☐ No
How many hours combined per day is a nurse on site overall, RN, LPN/LVN?	☐ Hours:
Do you have any other staff not mentioned above?	

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CARE	
What are the types of licensed nursing care and/or skilled care services monitored, assessed and/or provided by a licensed nurse, employed or contracted by the facility (Select all that apply)?	☐ Blood draws ☐ Catheter care ☐ IV therapy ☐ Monitor and administer sliding scale injectables ☐ Monitor and administer tube feedings (artificial feedings) ☐ Monitor and administer ventilator care ☐ Monitor and assess vital signs ☐ Monitor and treat uncomplicated skin breakdown ☐ Monitor, administer and adjust oxygen therapy ☐ Ostomy care ☐ Wound care (select all that apply) ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
What is the frequency of licensed nursing and/or skilled care services?	☐ Less Than 24 Hours/Day ☐ On-call ☐ 24 Hours/Day ☐ None
What type of licensed physician care services and/or supervision of care is provided by the facility?	☐ Physician/Medical Director on Staff – Routine Visits ☐ Physician/Medical Director not on Staff – residents use own physician ☐ Physician/Medical Director on Staff – On call
Does a physician oversee and sign off on plans of care?	☐ Yes ☐ No
What are the facility's procedures in the case of an emergency?	☐ Call 911 ☐ Physician On-Site ☐ Physician On Call ☐ Other:

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Facility offers personal assistance with which of the following?	☐ Ambulating/Mobility ☐ Bathing ☐ Continence ☐ Dressing ☐ Eating ☐ Toileting ☐ Transferring ☐ Foot Care
Are ADLs supervised by RN/LPN/LVN?	☐ Yes ☐ No
Does the facility provide medication management?	☐ Yes ☐ No
What medication management services are offered by the facility?	☐ Administration of insulin injections ☐ Administration of other injectable medications ☐ Maintain daily medication administration record ☐ Medication dosed by facility staff per MD orders ☐ Medication pre-dosed and sent from pharmacy (bubble pack) ☐ Medications provided by Facility Contracted Pharmacy ☐ Medications provided by Resident's Pharmacy ☐ Medicine stored under lock and key ☐ Other
What is the frequency of medication management that can be provided by the facility?	☐ Less than 24 Hours/Day ☐ On-call ☐ 24 Hours/Day ☐ None
Who provides medication management to residents?	☐ Facility Staff ☐ Contracted Staff
Does the facility allow residents to self-administer medications?	☐ Yes ☐ No If yes, select from options below: ☐ Medication reminders ☐ Medication set-up (medi-set) ☐ Prescription medications stored by and accessible to all residents (not under lock and key) ☐ Supervision for self-administration

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COMMUNITY	
Which dietary options are available in the facility?	☐ Ethnic meals ☐ Gluten-free ☐ Kosher meals ☐ Low sodium ☐ Low sugar ☐ Regular only ☐ Thickened foods and liquids ☐ Vegetarian
Which meals are served at the facility?	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snack

I affirm that the Facility Profile information provided here is accurate to my knowledge as of the date on which this form is being submitted to Senior Health Insurance of Pennsylvania (In Rehabilitation).

_____	_____
(Signature)	(Date)
_____	_____
(Name – printed)	(Title)
_____	_____
(Contact Number)	(Email Address)

*If you have not already provided a copy of your state issued license/business license or liability insurance, please include that information.