

PART C

TO BE COMPLETED BY LONG TERM CARE FACILITY

Instructions:

Please separate the service dates paid in-full by Medicare from the dates co-insurance was charged. Please separate confinements by month and, if hospitalized, by breaks in LTC confinements. Please separate ancillary and level of care charges as well.

Have any of these charges been submitted to or paid by Medicare? Yes No

Date of Services	Daily/Monthly Charge	Explanation of Services	*paid by Medicare in-full/ co-insurance
From: <input type="text"/> - <input type="text"/> - <input type="text"/> To: <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly \$ <input type="text"/> , <input type="text"/> . <input type="text"/>		<input type="checkbox"/> In-full <input type="checkbox"/> Co-ins
From: <input type="text"/> - <input type="text"/> - <input type="text"/> To: <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly \$ <input type="text"/> , <input type="text"/> . <input type="text"/>		<input type="checkbox"/> In-full <input type="checkbox"/> Co-ins
From: <input type="text"/> - <input type="text"/> - <input type="text"/> To: <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly \$ <input type="text"/> , <input type="text"/> . <input type="text"/>		<input type="checkbox"/> In-full <input type="checkbox"/> Co-ins
From: <input type="text"/> - <input type="text"/> - <input type="text"/> To: <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly \$ <input type="text"/> , <input type="text"/> . <input type="text"/>		<input type="checkbox"/> In-full <input type="checkbox"/> Co-ins
From: <input type="text"/> - <input type="text"/> - <input type="text"/> To: <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly \$ <input type="text"/> , <input type="text"/> . <input type="text"/>		<input type="checkbox"/> In-full <input type="checkbox"/> Co-ins
From: <input type="text"/> - <input type="text"/> - <input type="text"/> To: <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly \$ <input type="text"/> , <input type="text"/> . <input type="text"/>		<input type="checkbox"/> In-full <input type="checkbox"/> Co-ins
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From: <input type="text"/> - <input type="text"/> - <input type="text"/> To: <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly \$ <input type="text"/> , <input type="text"/> . <input type="text"/>		<input type="checkbox"/> In-full <input type="checkbox"/> Co-ins

Signature of person completing form: _____

Printed Name of person completing form: _____

Please attach a copy of your State license, and a copy of the Doctor's orders.