RIGHT ACCORD
Private Duty-Home Health Care

Name:_____ D.O.B.: _____ Last 4 SS#:_____

Insurance Provider: _____ Policy #:_____

Provider Phone #:_____ Provider Fax #: _____

LTC Agent Name:_____ LTC Agent Phone #: _____

Policy Overview

How much is the benefit for?

What is the daily maximum benefit?

What are the benefit triggers?

What kind of care does the policy cover?

Is there a waiver of premium?

Is there an elimination period?

How many days is the elimination period?

Is the Elimination period Service days or calendar days?

What types of care count toward the elimination? Hospital, Skilled Rehab, Therapy, etc?

Are there coverage exclusions?

Does waiver of premium begin during or after the elimination period has been met?

How do I add my Care Agency as an authorized representative that can submit and receive information about my policy?

Insurance Rep: _____ Agency Rep: _____

Today's Date:_____Claim Initiation Date:_____Claim #:_____

ADL's for Initiation:

☐ Bathing ☐ Dressing ☐ Toileting ☐ Transferring ☐ Continence ☐ Ambulation ☐ Cognitive