Trustmark
benefits beyond benefits

# Critical HealthEvents – Caregiver Benefit Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45708
For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

Name of Policy Owner: _____ Policy #: _____

## Physician Certification Statement

Medical Certification for: _____
(**Name of individual in need of Caregiver services**)

Physicians Name:_____

Business Address:_____

Medical/Surgical Specialty:_____

Telephone:_____ Fax:_____

The above patient requires Caregiving due to: (check all that apply)

❑ **Cancer** ❑ **Coronary Disease** ❑ **Cerebral Vascular Disease**

Date the clinical condition(s) diagnosed: ___/____/_____

Caregiving required for the following (check all that apply):

_____ **Home Health Care**: Personal care including assistance with bathing, dressing and personal hygiene, feeding; dressing changes, monitoring of vital signs, body positioning and basic exercise; medication administration, supervision for safety.

_____ **Homemaking**: Assistance with light housekeeping, shopping and meal preparation, laundry, medication management, bill paying.

_____ **Transportation**: Assisting individual in order to access needed services outside of home for medical professional services or rehabilitative care.

If Yes, as of what date? _____

Have these caregiving needs, individually or in combination, occurred at a minimum frequency of 3 times a week and been continuous for at least two weeks? ❑Y ❑N

**FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.**

Physician Signature_____ Date: _____

_ Are you, the physician, related to this patient? ❑Y ❑N

If yes, what is the relationship? _____

May we communicate with you via email? ❑Y ❑N

If yes, Email Address: _____