

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: