Bankers Life and Casualty Company BANKERSLIFE®

PROOF OF RESIDENCE FORM

Instructions

- *The Proof of Residence (POR) form is a required part of the monthly claim submission and must be completed in its entirety by **facility staff**.*
- *Ensure copies of BLANK POR forms are maintained by the facility. Additional forms can be found at www.BankersLife.com/Service-Support/.*
- *Complete a form each month, on or after the last day of the month, after the services have been provided and submit with the corresponding bill. (Example: Facility charges from June 1st – June 30th should not be submitted prior to July 1st)*
- *Incomplete forms and photocopies of a prior month's completed POR form will be considered ineligible and may delay the reimbursement process.*
- *Please make sure to complete the form using the correct dates. Please verify Month, Day, and Year while completing the form.*

Please complete the form and submit monthly with the corresponding bill. Send via fax (preferred) to (312) 396-5952, upload to www.BankersLife.com/Service-Support/Document-Upload, or mail to: Bankers Life, P.O. Box 1902, Carmel, IN 46082

Resident Name : ______________________ Facility Name: ______________________

Resident Policy #(s): ______________________ Facility Address: ______________________

______________________ ______________________

Resident Move-In Date: ______________________ (MM/DD/YYYY) Facility Phone Number: ______________________

Month of Service: **From:**__________ **(MM/DD/YYYY)** **To:**__________ **(MM/DD/YYYY)** Facility Fax Number: ______________________

1. Is the resident deceased? ☐ Yes ☐ No If Yes, please provide date of death: ______________________ (MM/DD/YYYY)
   Was the resident charged for services on the date of death? ☐ Yes ☐ No
2. Select the level of care that describes the resident's current room, unit, or apartment:
   ☐ Skilled Nursing Facility ☐ Assisted Living Facility ☐ Other: ______________________
3. At any time during this service period, was the resident away from the facility overnight for any reason? ☐ Yes ☐ No
   If Yes, provide dates: Departure Date: ______________________ (MM/DD/YYYY) Return Date: ______________________ (MM/DD/YYYY)
   Provide reason for absence: ☐ Hospitalization ☐ Voluntary leave ☐ Other: ______________________
   Was the resident charged for the days out of the facility?: ☐ Yes ☐ No If Yes, daily amount $: ______________________
4. Please explain any credits appearing on the bill: ______________________
5. Did Medicare, Medicaid/MediCal or any other insurance provide benefits during this service period?
   ☐ No ☐ Yes, Medicare
   ☐ Yes, Medicaid ☐ Other government insurance: ______________________

Please provide dates of 100% coverage/coinsurance/private pay below. Please include Explanation of Benefits or UB-04 form along with the bills and this form. ______________________

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By signing below, I declare that I have read the Fraud Notice on the reverse side of this form and that all of the answers given are complete and true to the best of my knowledge and belief.

Print Name **Title** **Phone Number**

Signature **Date (MM/DD/YYYY)**

Fraud Notice: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, files a claim or materials in support of a claim containing false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties.

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