

NHIC

National Heritage Insurance Company
12545 Riata Vista Circle
Austin, TX 78727

Tele: (800) 925-89567

Fax: (800) 514-4209

Date: _____ PCN _____ Client Name _____
Provider Name _____ Provider Medicaid No. _____
Provider Phone # _____ Fax _____

FUNCTIONAL STATUS FORM

Equipment being requested: _____

- Client's condition & functional status with head/neck & trunk control.

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- What was the client's functional/mobility status prior to the current condition?

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- Is the client bedbound? Yes _____ No _____ Duration of hours spent in bed _____
Hours spent out of bed _____ Ambulatory w/assistive device _____
Without device _____

Degree of Assistance: Maximum _____ Moderate _____ Minimum _____

- Height _____ Weight _____ Weight bearing capability _____

- Is there a caregiver assisting the client? If so, how many hours a day are they in the home? _____

- Growth potential, duration of need and weight limitation of needed equipment.

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- Manufacturer's name, model number, description of equipment, picture and itemized list of parts, price list and retail. _____

Please send the above medical documentation to NHIC/Home Health with a completed Title XIX form.s