Caregiver Benefit Evaluation

Additional Information Form

Your Name______________________________________**Title**___________________________

Corporation Name (if applicable) ____

Facility Name____

Address____

City_______________________________________ **State**_________ **Zip Code**____________

Telephone (_____**)**___________________________**Fax (**_____**)**___________________________

E-mail Address____

Licensed Beds: **Total#**_____ **Occupied#**_____ **Available#**_____

Medicare Beds: **Total#**_____ **Occupied#**_____ **Available#**_____

Average Private Daily Rate **$**______

Average Medicaid Daily Rate **$**______

Average Medicare Daily Rate **$**______

Average Number of Monthly Medicare Admissions and Re-admissions from the Hospital to your Facility (if available) ______

Please include the above information with your latest Provider Summary of Reimbursement (PS&R) and your Medicare Admission's Register for the last 12 months.

Mail or fax all information to:

Caregiver Management Systems, Inc
1111 N Plaza Dr, Ste 430
Schaumburg, IL 60173

Phone: 1-800-789-4836
Fax: 1-847-517-6714