How to File a Claim

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Getting Started

As soon as you need or think you may need formal (paid) long-term care (LTC) services, contact us and let us know about your condition. Call Customer Service toll-free at 1-800-982-1775 (Monday through Friday, 8:00 a.m. – 5:00 p.m. Pacific Time). Call even if you have not arranged for LTC services or don't know if you qualify for benefits. Starting a claim is as easy as making a phone call.

Filling Out a Claim Form

- We will provide you with a Claim and Medical Records Authorization Form (called the initial claim form). Complete, sign, and return this form. This will allow us to begin the process by obtaining information from your doctor or, if you are already receiving formal LTC services, from your service providers.
- If your legal representative signs the form for you, we need documentation of a power of attorney, guardianship, or conservatorship.
- If the claim form we receive is not complete, we will contact you and ask for the missing information or signature.
- In some cases, if you are unable to complete the claim form yourself, the interviewer discussed below may help you complete it.

Your In-Person Assessment and Provider Information

If you are living in your home or assisted living, you will usually have an in-person nursing assessment to help us evaluate your condition and determine what care you need. A trained professional will interview you where you live at a time convenient for you. We encourage you to have a family member present. We will make all arrangements and pay all costs.

The interviewer gathers information to assess your situation, abilities, and care needs and asks where you prefer to receive care and from whom. They will use a standardized

and objective assessment questionnaire to ensure that your condition is evaluated fairly. The interviewer does not make any decisions about your eligibility for benefits; they only collect information. It is very important that you meet with the interviewer as soon as possible so that we can quickly obtain all information we need to determine your eligibility for benefits.

In some cases (for instance, if you are in a nursing home), an in-person assessment is not necessary, and we rely on information from your care providers. A prompt response from them will help us process your claim quickly.

We Will Notify You

A Care Advisor assigned to you will objectively review information about your condition to determine if you meet the eligibility requirements for benefits (the Conditions for Receiving Benefits in your Evidence of Coverage). This process normally takes two to four weeks, but this varies depending on how quickly we can schedule an interview and how quickly your providers submit information. When the determination is made, we will notify you, both by telephone and in writing.

- If we determine that you are eligible for benefits, we will send you an approval letter.
- If you are eligible for benefits, your Care Advisor will work with you and your family to decide which type, level, and frequency of services will best meet your needs—the result of this collaborative process is your Plan of Care. If you need help to find a provider or initiate services, your Care Advisor can assist.
- If you are eligible for benefits, we will establish the earliest date for which there is documented evidence that you met the Conditions for Receiving Benefits. (You may have been eligible even before you contacted us.) This will be used in calculating your Deductible Period, discussed below.
- If we determine that you are not eligible for benefits, we will call you and then send a declination letter. You always have the right to ask for reconsideration or appeal this decision, and our letter will tell you how to do that. Even if you are not currently eligible for benefits, we can help you with information about supportive services and providers in your area.

Calculating Your Deductible Period

After you first meet benefit eligibility requirements, a certain amount of time must elapse before you begin receiving benefits. This is your Deductible Period (also called the Elimination Period), and it is a feature of your coverage that helps us hold down your premium. For most CalPERS Participants, the Deductible Period is 90 days. In most cases, it works like this:

- Your Deductible Period begins on the first day you both meet the eligibility requirements and receive covered formal (paid) LTC services. You must submit documentation of the formal services, such as a provider's bill and daily care notes.

- You must continue to meet the Conditions for Receiving Benefits for a specified number of calendar days (for most Participants, 90 days). When you have done so, your Deductible Period is satisfied, and you can begin to receive benefits.

- You do not have to continue receiving formal (paid) services during your Deductible Period. You just have to receive at least one day of formal services to start your Deductible Period. So you could receive just one day of paid services, then be cared for by family members during the rest of your Deductible Period, and after your Deductible Period is satisfied, you could resume paid services and pay for them with your benefits. Some people do this to avoid large expenses during the Deductible Period.

- For some types of care, such as respite care or hospice, you do not have to satisfy your Deductible Period before receiving benefits.

- You have to satisfy your Deductible Period only once during your lifetime. If you recover and stop receiving benefits but later need care again, you don't have to satisfy the Deductible Period again.

You or your legal representative should review the definition of the Deductible Period in your Evidence of Coverage and call us if you have questions.

Follow These Steps Listed Below

- **Step 1**- When you believe you are eligible for long-term care benefits please contact our administrator immediately to file a claim.
- **Step 2**- We may request medical records or provider verification documents to validate your claim.
- **Step 3**- Your deductible period will begin on your first paid date of service from an eligible provider.
- **Step 4**- Once you complete your deductible period (90 days or 30 days) you must continue to remain chronically ill.
- **Step 5**- Contact your care advisor to ensure eligible care is in place. Once your provider is approved, you may begin to submit invoices for review.