CalPERS Long-Term Care Claim Form

Claim Form

This document will assist you through the claim filing process. We must receive important information from multiple parties in order to appropriately evaluate each claim. In order for expenses to be applied to the Deductible Period or to be considered for reimbursement, all requested claim materials must be received.

The CalPERS Long-Term Care team is available to assist you throughout the process at (800) 982-1775.

Long-Term Care Claim Checklist

Filing a claim can be done in 4 steps:

1. Call the Intake Team
2. Provide authorized representatives
3. Complete the claim form
4. Submit documentation

During the initial claim filing process, we may ask for additional information from you and/or your provider(s) to learn more about your condition and care needs.

Step 1: Call the Intake Team before you file a claim

Before you file a claim, please contact one of our Intake Specialists. They will work with you one-on-one to answer your questions, walk you through your plan benefits and assist you with the claim filing process. You can reach an Intake Specialist at (800) 982-1775, Monday through Friday between 8:00 a.m. and 5:00 p.m. Pacific Time.

Intake Specialists can assist with such questions as:

- Who are qualified providers in my area?
- What types of services and expenses does my specific plan actually cover?
- What are my dollar limits?
- What factors are considered to determine if I qualify to receive plan benefits?
- What is a Deductible/Elimination Period?
- Must I satisfy a Deductible/Elimination Period before I file a long-term care claim?
- What information may be requested during the claim process?
- How quickly can I expect a decision on my claim?
- What do I need to submit to receive reimbursement?

Step 2: Fill out the claim form

Once your care begins, you will need to complete a claim form. Please keep the following items in mind when filing an LTC claim:

- Provide as much detail as possible to each of the questions, including your and your providers' current addresses and telephone numbers. Providing incomplete information may lengthen the claim processing time.
- Feel free to attach additional pages if you need more room to respond to any question.
- Sign the enclosed Authorization for Use and Disclosure of Protected Health Information form included with the claim packet.
- If available, please submit a copy of your Government Issued Photo Identification (ID) such as your driver's license, state issued ID card or passport.

Step 3: Provide authorized representatives

If you will not be handling your claim personally, CalPERS will need one of the following so an authorized representative can manage the claim on behalf of the participant:

1. A signed Third Party Authorization Form, or
2. A copy of the Healthcare or Durable Power of Attorney document

This form is written assuming "you" are the participant.

Step 4: Submit documentation

Mail the completed claim form, a copy of your Government Issued Photo Identification (ID) such as your driver's license, state issued ID card or passport and all available claim documentation to:

CalPERS Long-Term Care Program

P.O. Box 64902

St. Paul, MN 55164-0902

FAX: (866) 294-6967

We will contact you or your designated representative within five to ten business days of receipt of your documents to advise that we have received your request for benefits and inform you if additional information is needed.

What to expect after submitting your claim

The following is a list of items we may request from your care provider in order to process your claim. Your help in gathering documentation is greatly appreciated as it will decrease the likelihood of delays or closure of your claim due to missing information. Referenced below are Provider types along with a list of specific items we may need to collect in addition to the claim form:

If you are unsure of what type of provider is covered by your plan or need assistance in locating an eligible provider in your area, please contact our Intake Team for assistance at (800) 982-1775.

Please call us throughout the duration of your claim if your care needs increase or decrease, if you have facility room changes, or have provider changes so that we may ensure your Plan of Care and benefit payments are accurate.

From a Nursing Home:

1. Minimum Data Set (MDS): This information is collected by the nursing home staff in order to assess (measure) your physical, psychological, and social functioning.
2. Itemized Bill(s): This document shows the charges (by reason) you have incurred during care. The charges need to be itemized in order for us to verify which expenses are covered by your plan.
3. Facility License: A document showing that the Facility is licensed or certified.

From a Home Health Care Provider

1. Plan of Care: A set of actions the care Provider will implement in order to resolve and/or support your diagnoses and/or care needs.
2. Daily Visit Notes: Documentation of the specific care provided during each visit by the caregiver. This documentation may also be referred to as: daily progress notes, nursing notes, staff notes, or charts.
3. Itemized Bill(s): This document shows the charges (by reason) you have incurred during care. The charges need to be itemized in order for us to verify which expenses are covered by your LTC plan.
4. Initial Provider Assessment: A written summary that provides a general description of you (physical assessment, height, weight, age, etc.) and a description of your primary medical history.
5. Provider qualifications including licensing for Agency, Aide, Caregiver, etc., as well as certification, and/or individual training or experience, if applicable per your plan.

From an Assisted Living Facility/Residential Care Facility

1. Facility's Service Plan: A set of actions the care Provider will implement in order to resolve and/or support your diagnoses and/or care needs.
2. Medication List: A list of all the medications you are taking and information on how they are to be administered.
3. Itemized Bill(s): This document shows the charges (by reason) you have incurred during care. The charges need to be itemized in order for us to verify which expenses are covered by your plan.
4. Facility License: A document showing that the Facility is licensed or certified.

From an Adult Day Care Provider

1. Adult Day Care Plan of Care: A set of actions the care provider will implement in order to resolve and/or support your diagnoses and/or care needs.
2. Itemized Bill(s): This document shows the charges (by reason) you have incurred during care. The charges need to be itemized in order for us to verify which expenses are covered by your LTC plan.
3. Facility License: A document showing that the Facility is licensed or certified.

Questions

If you do not see your provider type listed or have additional questions, please contact our Intake Team at (800) 982-1775, Monday through Friday between 8:00 a.m. and 5:00 p.m. Pacific Time.

Notes

If any testing such as Mini Mental State Exam (MMSE) or a neuropsychological evaluation has been completed, please include this information in your claim submission.

A Benefit Eligibility Assessment (BEA) may be requested during our eligibility review. This is a visit by a qualified licensed healthcare practitioner from an independent agency (not affiliated with the CalPERS Long-Term Care Program) who conducts an assessment with you in your place of residence. During the assessment, this individual will gather information about your functional abilities. They will also administer a cognitive screening and discuss your relevant medical history and current health conditions.

Please be advised that in order for us to process your claim it must be either mailed or faxed to us at:

CalPERS Long-Term Care Program

P.O. Box 64902

St. Paul, MN 55164-0902

FAX: (866) 294-6967

If you have any questions about the process, please call Customer Service toll free at (800) 982-1775, Monday through Friday between 8:00 a.m. and 5:00 p.m. Pacific Time. You may also find us online at www.calperslongtermcare.com.

Additional items

If you wish to use direct deposit for your benefit payments please complete and return the included Direct Deposit Form for Long-Term Care Claim Reimbursements. If the direct deposit is for a service provider, an Assignment of Benefits Form and a current W9 is required for the direct deposit request to be completed.

You may elect to have benefits assigned directly to a service provider. To establish an assignment of benefits you must first establish if the provider is willing to consider assignment. The service provider will need to submit their Tax Identification Number (Social Security Number for Independent Provider) and complete the included W-9 to have the payment be made directly to the service provider.

The assignment of benefits will not be in effect until the CalPERS Long-Term Care Program has received the completed form. Note the assignment of benefits may be terminated in the future upon receipt of a written request stating you wish to revoke the assignment.

Completed Assignment of Benefits, W9, and Direct Deposit forms can be returned by mail to CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164-0902, or faxed to 1-866-294-6967

Long-Term Care Claim Form

<u>Please send completed claim form to:</u> CalPERS Long-Term Care Program

P.O. Box 64902

St. Paul, MN 55164-0902

Fax: (866)294-6967

If you need assistance or have questions about submitting your claim, please call (800) 982-1775.

1. Participant Name:_____ Date of Birth:_____

   Address: _____ City:_____ State:_____ Zip:_____

   Phone: _____ Gender: ❑ M ❑ F

2. Contact Person (if unable to reach) Name: _____

   Address: _____ City: _____ State: _____ Zip: _____

   Phone: _____ Relationship: _____

3. Have you appointed someone to have Power of Attorney for you, or do you have a court appointed Conservator or Legal Guardian?

   *If Yes, please complete below. If you have appointed more than one person to represent you, provide information on the other person(s) on a separate sheet. Please attach a copy of the legal documents executing the Power of Attorney, Conservatorship, or Legal Guardianship to this claim form before returning.

   Name_____

   Address:_____ City:_____ State:_____ Zip:_____

   Phone: _____

Please note that in accordance with The Health Insurance Portability and Accountability Act (HIPAA), we will not disclose information to individuals who do not hold Power of Attorney, or who are not listed in your claim as an Authorized Individual. In order to authorize an individual please complete an Authorization for use and Disclosure of Protected Health Information form, which requires the participant's signature or the signature of a legal representative.

4. What cause(s) or condition(s) result in your need for long-term care? (i.e., illness, injury or accident): _____

   _____

5. If your care needs were caused by an injury/accident, when, where and how did the injury/accident occur?

   _____

   _____

6. If your care needs were caused by an injury/accident, are you represented by an attorney in this matter? Please provide the following information about your attorney:
   Name: _____ Phone: _____

   Address: _____ City: _____ State: _____ Zip: _____

7. Please describe what long-term care assistance you think you need and when the need for such assistance began: _____

   _____

8. Are you currently hospitalized, or have you been hospitalized within the last year?
   Hospital Name/Address: _____

   From: _____ To:_____

9. Please provide the following information:
   (Please attach additional pages if necessary)

   Name of Current Physician: _____Specialty:_____

   Address: _____

   City: _____State:_____ Zip:_____

   Phone: _____

   Condition(s) being treated _____

   From: _____ To:_____

Name of Current Physician: _____Specialty:_____

Address: _____

City: _____State:_____ Zip:_____

Phone: _____

Condition(s) being treated _____

From: _____ To:_____

10. Please complete the information below if applicable:
(Please attach additional pages if necessary)

NURSING HOME, ASSISTED LIVING, RESIDENTIAL CARE FACILITY

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax #: _____

Date Admitted: _____ Date Discharged: _____

Payer Source: _____

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax #: _____

Date Admitted: _____ Date Discharged: _____

Payer Source: _____

HOME HEALTH CARE OR ADULT DAY CARE SERVICES

Name of Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax #: _____

Date Admitted: _____ Date Discharged: _____

Payer Source: _____

11. Do you currently have coverage for medical care under Medicare?

❑ No Medicare coverage ❑ Part A only ❑ Part B only ❑ Part A and B

Has a claim been submitted? ❑ Yes ❑ No

12. Do you have any other insurance that may provide coverage? **(Check all that apply)**

❑ Coverage under a Medical Plan Company _____ Policy #: _____ Phone: _____ Has a claim been submitted? ❑ Yes ❑ No	❑ Worker's Compensation Company _____ Policy #: _____ Phone: _____ Has a claim been submitted? ❑ Yes ❑ No
❑ Supplement to Medicare Company _____ Policy #: _____ Phone: _____ Has a claim been submitted? ❑Yes ❑No	❑ Other Long-Term Care Company _____ Policy #: _____ Phone: _____ Has a claim been submitted? ❑ Yes ❑ No
❑ Other Third Party Coverage (Auto Insurance, Injury/Accident, Property Insurance, etc.) Company _____ Policy #: _____ Phone #: _____ Has a claim been submitted?❑ Yes❑ No	
❑ No Insurance	❑ Unknown

For your protection some states require us to inform you that any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. If we determine that benefits have been paid under this coverage as a result of your fraudulent action(s), we have the right to recover those benefit amounts. We may recover those benefit amounts directly from you or by reducing any subsequent benefit payments under this coverage. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

I declare that all of the answers given are complete and true to the best of my knowledge and belief. I understand that the company reserves the right to require further proof.

Signature of Participant (or Participant's Representative)	Date signed (Month, Day, Year)
Participant (or Participant's Representative) Name	Signed at (City, State)
If Representative, give relationship to Participant	

AUTHORIZATION FORM

PARTICIPANT NAME: _____ DOB:_____

I AUTHORIZE THESE PERSONS or institutions having any records or knowledge of me or my health:

- Any physician, medical practitioner, or health care provider
- Any hospital, clinic, pharmacy or other medical or medically related facility, or association
- Any insurance company or insurance support organization
- Any employer or plan administrator
- Any government agency
- Any organization or entity administering a benefit program
- Any rehabilitation organization or program
- Any financial institution, consumer reporting agency, accountant, or tax preparer

TO GIVE THIS INFORMATION:

Chart notes, x-rays, operative reports, lab and medication records and all other medical information about me, including *medical history, diagnosis, examinations, testing and test results, prescriptions, prognosis and treatment of any physical or mental condition including:*

- Any disorder of the immune system including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes. **Note:** In the state of Minnesota, this Authorization does not include the performance of, or the results of, a test to determine the presence of the Human Immune Deficiency Virus (HIV) antibody given to (a) an offender, as defined under Minnesota law; or (b) a crime victim because of exposure to, or contact with, such an offender.
- Any communicable disease or disorder.
- Any psychiatric or psychological condition, including test results.
- Any condition, treatment, or therapy related to Substance Abuse, including Alcohol and Drugs; **and**
- Any non-medical information including such things as eligibility for other benefits, earnings, or finances.

TO THE CALPERS LONG-TERM CARE PROGRAM:

- I understand that the CalPERS Long-Term Care Program will use the information to determine my eligibility for benefits.
- CalPERS Long-Term Care Program may release information about me to its affiliates, or any person performing business or legal services for the CalPERS Long-Term Care Program in connection with my claim. I ACKNOWLEDGE THAT I HAVE READ THE AUTHORIZATION and I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with the CalPERS Long-Term Care Program. A photocopy of this authorization is as valid as the original.
- I may revoke this authorization at any time by providing written notice to the CalPERS Long-Term Care Program.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the CalPERS Long-Term Care Program or protected by the privacy rules under the Health Insurance Portability and Accountability Act.
- I understand that I have the right to refuse to sign this Authorization, but if I do not sign the Authorization, the CalPERS Long-Term Care Program will not be able to determine my eligibility for benefits.

_____

Signature of Participant (or Participant's Representative) Date signed (Month, Day, Year)

*All signatures, other than that of the Participant, must be identified and accompanied by appropriate documentation of authority to represent the Participant (for example: Durable Power of Attorney, Conservator, or Guardian).

AUTHORIZATION FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION TO AN AUTHORIZED INDIVIDUAL/PERSONAL REPRESENTATIVE

PARTICIPANT NAME: _____ **Coverage ID:** _____

I, _____, hereby authorize the use and disclosure of my protected health information for: Coverage administration, billing information, and or claims information, or as defined, or as limited to the following:

_____

_____

CalPERS Long-Term Care Program may release my protected health information as described above to the following person(s) (Please make copies if you are designating more than one):

_____

Printed Name of Authorized Individual Phone Number

_____

Street Address

_____

City State Zip Code

This form is for use and disclosures only; it does not authorize anyone other than me or my legal representative to make any changes to my coverage, billing or demographic information. I understand that if the person or entity that receives my information is not covered by federal privacy regulations, my information may be re-disclosed by such person or entity, and will then no longer be protected.

This authorization is valid until my coverage ends, unless a specific expiration date or event is specified here: _____. I understand that I may revoke this authorization in writing at any time. I am entitled to make a copy of, or request to receive a copy of this authorization.

I understand that I am not required to sign this authorization and that payment or eligibility will not be conditioned upon my choice not to sign. I further understand that my protected health information cannot be disclosed to any unauthorized third party without my signature.

I acknowledge by my signature below that I have read and understand this Authorization, it accurately reflects my wishes, and a photocopy, facsimile, or other electronic copy is as valid as the signed original.

_____

Signature of Participant or *Legal Representative Date

*If you are signing as a legal representative, describe the scope of your authority to act on their behalf and include a copy of the documentation of your legal authority.

DIRECT DEPOSIT FORM FOR LONG-TERM CARE CLAIM REIMBURSEMENTS

PARTICIPANT NAME: _____ **Coverage ID:** _____

Section I – Name for Direct Deposit Setup

_____
Payee Name

_____
Social Security # or Federal Tax ID #

Section II – Direct Deposit Information

Check off one: ❑ Initial setup ❑ Account Change

Enter the account where payment should be disbursed. The nine-digit transit number and account number is encoded at the bottom of your check. A copy of a VOIDED CHECK or SAVINGS ACCOUNT WITHDRAWAL SLIP ***must*** be attached to ensure the correct numbers are obtained. Please allow six weeks for setup of direct deposit.

Account Type: ❑ Checking ❑ Savings

Bank Name	Transit Number	Account Number

Section III – Authorization

I hereby authorize the CalPERS Long-Term Care Program to initiate credit entries to the Bank indicated by the Transit Number on this form. If necessary, I also authorize, debit entries and adjustments for any credit entries in error to my account indicated on this form. The authority is to remain in full force and effect until the CalPERS Long-Term Care Program has received written notification from me of its termination in such time and in such manner as to afford the CalPERS Long-Term Care Program and the Bank a reasonable opportunity to act on it.

_____ _____
Signature of Account Holder Date

_____ _____
Account Holder Name Account Holder Phone

CALPERS LONG-TERM CARE PROGRAM

ASSIGNMENT OF BENEFITS

PARTICIPANT NAME: _____ Coverage ID: _____

In the event you would like to assign benefits you must first establish if the provider is willing to consider assignment. The service provider will need to submit their Tax Identification Number and complete the attached W-9 so the payment will be made directly to the service provider. The additional steps required are listed below. If you and the provider have agreed to establish an assignment of benefits, please complete the below form and W-9 and return to us at:

CalPERS Long-Term Care Program
P.O. Box 64902
St. Paul, MN 55164-0902
Fax #: 1-866-294-6967

The assignment of benefits will not be in effect until the CalPERS Long-Term Care Program has received the completed form. Note the assignment of benefits may be terminated in the future upon receipt of a written request stating you wish to revoke the assignment.

I,_____, the Participant or the guardian of the Participant (legal documentation of guardianship or other representative capacity, if appropriate, is attached), hereby authorize direct payment to _____of any Long-Term Care benefits otherwise payable to or on behalf of the Participant for the service provider at a rate not to exceed the Provider's regular charges. It is agreed that payment to the Provider, pursuant to this Assignment of Benefits, by the plan administrator shall discharge CalPERS Long-Term Care Program of any and all obligation under the plan to the extent of such payments. It is understood by the undersigned that he/she is financially responsible for any charges not covered by this Assignment of Benefits. This Assignment of Benefits is valid for the CalPERS Long-Term Care Program.

_____ _____

Service Provider Representative Signature | Participant/Legal Representative Signature

_____ _____

Printed Name of Service Provider | Printed Name of Participant/Legal Representative

_____

Date

❑ Financial Power of Attorney is attached or already on file if signed by a Legal Representative

Federal Tax ID # or Independent Provider Social Security (last 4) #: _____

Name of Service Provider:_____

Address of Service Provider: _____

City: _____ State: _____ Zip:_____