THRIVENT FINANCIAL®

Appleton, Wisconsin · Minneapolis, Minnesota
Thrivent.com · 800-847-4836

Long-Term Care Insurance Claim Packet

Use these forms to file a Long-Term Care Insurance claim and have them completed as soon as possible after your claim begins.

Instructions:

1. **Claimant Statement -** You (or a person acting for you) must complete the Claimant Statement portion of this packet.

2. **Provider Service Report -** A representative from each health care facility or agency from which you received care must complete the Provider Service Report portion of this packet. Make additional copies as needed. This form is also available on our website - Thrivent.com.

3. **Attending Physician Statement/Plan of Care -** The physician who is primarily responsible for your care must complete the Attending Physician Statement/Plan of Care portion of this packet.

4. If you have a **Durable Power of Attorney (DPOA) for Finances or a Guardian,** provide a copy of that document.

5. **The claimant is responsible for charges incurred for the completion of these forms.**

6. **Send the initial billing statements from each qualifying care provider. If your claim is approved, we will let you know in the approval letter if additional bills are needed.**

Return the completed claim form(s) and supporting documents to: **Long-Term Care Claims**
Thrivent Financial
PO Box 8075
Appleton, WI 54912-8075
or fax to **800-225-2264.**

Refer to your contract or rider for specific benefit information. If you have any questions concerning benefit eligibility, the completion of the enclosed forms, or the handling of your claim, we encourage you to call Long-Term Care Claims at 800-847-4836.

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Long-Term Care Insurance Claim Packet

Member ID	Contract number

Claimant Statement

Name of claimant

Nature of sickness or injury

☐ Yes ☐ No Is Medicare covering/has Medicare covered any of claimant's Long-Term Care services?
If yes, dates - _____

Name of attending physician	Phone of attending physician

Address of attending physician

City	State	ZIP code

Claimant is applying for: ☐ Nursing home ☐ Assisted living ☐ Home care ☐ Respite care
☐ Independent living ☐ Other (specify) - _____

Date when facility confinement or services began - _____

☐ Yes ☐ No Is claimant still receiving these services? **If no,** date when care ended - _____

Name of home health care agency, nursing facility or provider of care, if currently being used or planned for use	Date of admission

Address	Phone

City	State	ZIP code

Name of previously used home health care agency, nursing facility or provider of care	Date

Address	Phone

City	State	ZIP code

Continued on page 3.

Claimant Statement (continued)

☐ Yes ☐ No Does someone hold a Durable Power of Attorney for finances document for the claimant?

☐ Yes ☐ No Does someone hold a Guardianship document for the claimant?

If yes, list the Power of Attorney or Guardian below and attach a copy of this document.
If no, list the name of the person we can contact with questions.

Name	Relationship	
Address	Phone	
City	State	ZIP code

Signature for Claimant Statement

For your protection, state laws require the following to appear on this form: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files or facilitates the filing of a statement of claim containing any materially false information, or conceals information concerning any fact material to the statement, may be guilty of insurance fraud, which may be a felony crime, subject to civil penalties or criminal prosecution, including substantial fines and/or confinement in prison.

Signature of person completing the form	Date signed	Relationship to insured
X		

Direct Deposit Authorization

Full name of bank	Routing number	Account number	
Name of bank account owner or business		☐ Checking ☐ Savings	
Address of bank account owner	City	State	ZIP code
Name of joint bank account owner			
Address, if different than above	City	State	ZIP code
Email of account owner			

General Authorization

I authorize Thrivent Financial for Lutherans ("Thrivent Financial") to:

- make electronic deposits, withdrawals, and corrections to my bank account that comply with U.S. law;
- act on this authorization until I revoke it by contacting Thrivent Financial;
- apply this authorization to any future bank accounts I may designate;
- make administrative changes to this authorization which I request such as date and amount changes, or adding or removing contracts for automatic payment;
- release any and all information related to this authorization to the third party account/contract owner;
- act upon electronic deposit, credit, and administrative instructions I provide to my financial representative.

Signature of account owner and date signed	Date signed

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Provider Service Report Instruction Page

A representative from each health care facility, agency, or independent care provider from which care was received must complete a Provider Service Report. Make additional copies for this purpose as needed. Any cost for completion of this form is the responsibility of the claimant.

Instructions:

1. Complete the entire Provider Service Report.

2. **Attach a copy of any or all of the items below, if available. Check each item sent.**

   - ☐ Your facility license(s) or additional certifications for the area of the facility where the claimant resides or for the services you provide, if a license is required by state or federal regulations.
     - ☐ License not required by state or federal regulation
     - ☐ No license available
   - ☐ Admission Assessment
   - ☐ Cognitive Test Results, including date of test, (such as Mini Mental State Examination (MMSE), St Louis University Mental Status (SLUMS), or Montreal Cognitive Assessment (MOCA))
   - ☐ Plan of Care/Care Plan/Individual Service Plan, prepared and signed by a Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)
   - ☐ Hospital Discharge Summary, if applicable
   - ☐ Initial Billing statements from each qualifying care provider. Additional bills may be needed.

3. Return the completed form(s) and supporting documents to: **Long-Term Care Claims**
   Thrivent Financial
   PO Box 8075
   Appleton, WI 54912-8075
   or fax to **800-225-2264.**

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Provider Service Report

Nursing Facility, Home Health Care Agency, Other

Member ID	Contract number

Name of claimant (Print first, middle, last name and suffix, as applicable)

Name of facility/provider		Provider relationship to claimant, if any	
Address of facility/provider	City	State	ZIP code
Phone of facility/provider	Fax number of facility/provider		

Certification - Must be signed by a Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)

I certify that the above named patient (check at least one box):

- ☐ Is unable to perform without hands-on or standby assistance from another individual, _____ Activities of Daily Living (ADLs) due to loss of functional capacity and this condition is expected to last for at least 90 days; **OR** due to a cognitive impairment, requires supervision to protect her/him self or others from threats to health or safety, which may include cueing by verbal prompting, gestures, or other demonstrations.
- ☐ Does not need assistance for at least 90 days to perform the activities of daily living and does not require supervision due to a cognitive impairment.

As signer, I certify that I am (check one box):

- ☐ A physician licensed in the United States within the meaning of Section 1861(r)(1) of the Social Security Act who is a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which I perform such function or action.
- ☐ A registered professional nurse (i.e., Registered Nurse (R.N.), B.S.N., M.S.N., or Nurse Practitioner).
- ☐ A licensed social worker (L.S.W.) who has the requisite educational degree(s) and who is qualified by training to assess physical and cognitive impairment.
- ☐ No registered professional nurse (i.e., Registered Nurse (R.N.), B.S.N., M.S.N., or Nurse Practitioner) or licensed social worker (L.S.W.) on staff.

Printed Name of Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)

Signature of Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)	Date signed
X	

Services provided by facility/provider to this claimant: ☐ Nursing home ☐ Assisted living ☐ Home care ☐ Independent living ☐ Respite care ☐ Other (specify) - _____

On what date did your services begin? _____

☐ Yes ☐ No Is the claimant still at your facility?

If the claimant has been discharged from your care, indicate last date of service - _____

☐ Yes ☐ No Was there a change of condition after admission to your facility?

If yes, what date did the change occur? _____

☐ Yes ☐ No Is Medicare covering/has Medicare covered any of the claimant's stay/services? **If yes**, dates are required.

_____

Continued on page 6

Provider Service Report - Nursing Facility, Home Health Care Agency (continued)

Claimant's diagnosis and impairment:

☐ Yes ☐ No Does the claimant need help or supervision because of a deficiency in the ability to think, perceive, reason and remember? **If yes**, explain the services you or your facility provides, relating to the cognitive impairment. NOTE: Medication management is not a benefit eligibility trigger.

Indicate the level of assistance you are **providing** with the following Activities of Daily Living (check all that apply). Occasional assistance should be noted.

Bathing:
- ☐ Independent
- ☐ Total assistance
- ☐ Standby/hands-on assistance
- ☐ Cueing/reminders only

Frequency of assistance - _____

Transferring:
- ☐ Independent
- ☐ Total assistance
- ☐ Standby/hands-on assistance
- ☐ Cueing/reminders only

Frequency of assistance - _____

Continence:
- ☐ Continent
- ☐ Incontinent, self-managed
- ☐ Incontinent, staff assistance with pericare
- ☐ Cueing/reminders only

Frequency of assistance - _____

Ambulation/Walking Indoors:
- ☐ Independent - with or without cane/walker/wheelchair
- ☐ Bed bound
- ☐ Wheelchair dependent and assistance provided
- ☐ Standby/hands-on assistance
- ☐ Cueing/reminders only

Frequency of assistance - _____

Eating (does not include preparing meals):
- ☐ Independent
- ☐ Aspirates (choking danger when fed)
- ☐ Is spoon fed
- ☐ Assistance getting food to mouth
- ☐ Cueing/reminders only

Frequency of assistance - _____

Dressing:
- ☐ Independent
- ☐ Fastening buttons/zippers
- ☐ Putting on/taking off clothes
- ☐ Selecting clothing/getting from closet or dresser
- ☐ Application of Ted Hose
- ☐ Cueing/reminders only

Frequency of assistance - _____

Using the Toilet:
- ☐ Independent
- ☐ Assistance performing pericare
- ☐ Total assistance
- ☐ Assistance getting on/off toilet
- ☐ Assistance getting to/from toilet
- ☐ Cueing/reminders only

Frequency of assistance - _____

Additional comments

For your protection, state laws require the following to appear on this form: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files or facilitates the filing of a statement of claim containing any materially false information, or conceals information concerning any fact material to the statement, may be guilty of insurance fraud, which may be a felony crime, subject to civil penalties or criminal prosecution, including substantial fines and/or confinement in prison.

Authorized signature of provider (facility, home health agency, other)	Date Signed
X	

Title

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Attending Physician Statement/Plan of Care

Member ID	Contract number

Any cost for completion of this form is the responsibility of the patient.

Name of patient	Date of birth

Date you last assessed this patient

If you have not assessed this patient within the last six months, please conduct an evaluation before completing this form.

Certification - Must be signed by a Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)

I certify that the above named patient (check at least one box):

- ☐ Is unable to perform without hands-on or standby assistance from another individual, _____ Activites of Daily Living (ADLs) due to loss of functional capacity and this condition is expected to last for at least 90 days; **OR** due to a cognitive impairment, requires supervision to protect her/him self or others from threats to health or safety, which may include cueing by verbal prompting, gestures, or other demonstrations.
- ☐ Does not need assistance for at least 90 days to perform the activities of daily living and does not require supervision due to a cognitive impairment.

As signer, I certify that I am (check one box):

- ☐ A physician licensed in the United States within the meaning of Section 1861(r)(1) of the Social Security Act who is a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which I perform such function or action.
- ☐ A registered professional nurse (i.e., Registered Nurse (R.N.), B.S.N., M.S.N., or Nurse Practitioner).
- ☐ A licensed social worker (L.S.W.) who has the requisite educational degree(s) and who is qualified by training to assess physical and cognitive impairment.

Printed Name of Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)

Degree

Address	City	State	ZIP code

Phone	Fax number

Signature of Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)	Date signed
X	

For your protection, state laws require the following to appear on this form: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files or facilitates the filing of a statement of claim containing any materially false information, or conceals information concerning any fact material to the statement, may be guilty of insurance fraud, which may be a felony crime, subject to civil penalties or criminal prosecution, including substantial fines and/or confinement in prison.

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Attending Physician Statement/Plan of Care (continued)

Primary medical diagnosis and ICD code(s):

Provide list of cognitive test scores, if available:

☐ Yes ☐ No Does the patient need help or supervision because of a deficiency in the ability to think, perceive, reason and remember?

Plan of Care

Type of Care Recommended (Assisted living, nursing home, home health care, etc)	**Reason for Care** (Describe claimant's physical or cognitive impairment)	**Frequency per Week and Hours per day** (Daily, weekly, bi-weekly, etc.)	**Duration of Care** (How long is the care expected to last?)

Please indicate if the claimant is getting hands on or standby assistance with ANY of the following:

Bathing:
☐ Yes Level of assistance _____
☐ No
☐ Cueing/reminders only

Continence:
☐ Incontinent Level of assistance _____
☐ Continent

Transferring:
☐ Yes Level of assistance _____
☐ No
☐ Cueing/reminders only

Using the Toilet:
☐ Yes Level of assistance _____
☐ No
☐ Cueing/reminders only

Eating (does not include preparing meals):
☐ Yes Level of assistance _____
☐ No
☐ Cueing/reminders only

Dressing:
☐ Yes Level of assistance _____
☐ No
☐ Cueing/reminders only

Ambulation/Walking Indoors:
☐ Yes Level of assistance _____
☐ No
☐ Cueing/reminders only

Additional comments

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