The Federal Long Term Care Insurance Program

Using Your FLTCIP Benefits

FLTCIP 1.0

The **Federal** Long Term Care Insurance Program™

Introduction

Thank you for your participation in the Federal Long Term Care Insurance Program (FLTCIP). For FLTCIP enrollees who have met the conditions for benefit eligibility, this brochure is intended to assist you at the time of claim by providing an overview of the process. It also contains important forms and instructions and offers valuable detail and support for the reimbursement of approved care expenses.

Note: This brochure provides an overview of the claims process. It does not replace the most recent *FLTCIP 1.0 Benefit Booklet* we sent you. Only the benefit booklet contains governing contractual provisions. For more detailed information or if you have any questions about your FLTCIP coverage, refer to your current schedule of benefits and benefit booklet, or contact us at **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 711.

1 Establish an approved plan of care

Now that you are eligible for benefits, a FLTCIP care coordinator—a registered nurse experienced in long term care—will work with you to develop your plan of care. Your plan of care is developed from your personal health information and care recommendations from your health care practitioner and is approved by our care coordination staff.

Your plan of care is used to validate invoices we receive for reimbursement of qualified long term care services. It will include details such as approved providers, dates of service, facility charges, hourly rates for caregivers, and quantified time for specific care services.

Any requested change to your plan of care must be reviewed and approved by our care coordination staff prior to making the change in order to avoid reimbursement denials or delays.

Decide where your care will take place

Our care coordination staff will work with you to help ensure that your long term care is provided in an appropriate setting to best meet your personal needs.

The chart below provides an overview of where your care may take place.

If you have comprehensive coverage

Care may take place inside your home, which means your personal place of residence that is not a licensed facility.

Types of providers allowed

- informal caregivers
  - friends
  - family members
  - private caregivers
- formal caregivers
  - home health agencies
  - home care agencies
  - visiting nurse associations
  - hospice agencies

Please note: These types of providers are all referred to as home care agencies throughout the brochure.

Care may also take place outside your home in a licensed facility.

Types of providers allowed

- adult day care centers
- assisted living facilities
- nursing homes
- hospice facilities

If you have facilities-only coverage

Care may take place outside your home in a licensed facility.

Types of providers allowed

- assisted living facilities
- nursing homes
- hospice facilities

1 Establish an approved plan of care (continued)

Now that you have a better understanding about where long term care services can take place, your care coordinator will help you:

- determine what services you need
- identify care providers in your area
- decide who will take care of you
- monitor the care you are receiving
- adjust your plan of care as your needs change

Alternate plan of care

A care coordinator can authorize benefits for services for your care that are not specifically defined as FLTCIP covered services. For example, under an alternate plan of care, we may consider a facility that is not otherwise covered under the FLTCIP. If you selected the comprehensive option, a care coordinator may also authorize benefits for supplemental items that enable you to remain at home, such as home modifications or durable medical equipment. The expenses you intend to incur for these alternative services must be preapproved before they are applied to a plan of care and submitted for reimbursement. To learn more about this process, contact Customer Service at **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 711.

Coordinate benefits

Some enrollees may be eligible for benefits for long term care services under another insurance plan or through other programs. For this reason, the FLTCIP includes a coordination of benefits (COB) provision, which follows the guidelines set by the National Association of Insurance Commissioners.

In determining the amount of benefits we will pay, this COB provision allows us to look at other plans—such as government programs, group medical benefits, and other employer-sponsored long term care insurance—that may pay benefits for the long term care services you receive.

If the FLTCIP is primary (meaning it pays first), we will pay benefits without coordinating with other plans. This means we will pay benefits to the maximum extent permitted by your coverage.

Although we do not coordinate benefits with Medicaid, we may be required by state law to notify your state Medicaid office about your coverage under the FLTCIP. In addition, we reserve the right to notify your applicable state Medicaid office about your FLTCIP coverage, as may be appropriate.

If another plan or program is primary, then it will pay first for the services they cover. In this case, we will require you to submit the explanation of benefits you received from that other plan or program showing that you submitted a claim to it and how that claim was decided. We may also request a copy of the other plan, program booklet, or terms of coverage. We will pay no more than the difference between the amount payable by your other coverage(s) and your actual covered expenses up to the daily benefit amount you selected.

Note: When Medicare is the primary plan, the services they cover are not eligible for reimbursement under the FLTCIP.

2 Identify caregivers

Our care coordination staff has access to more than 200,000 providers of daily care, home modification, skilled nursing, and much more to help you maintain your independence as you age. Providers must meet the qualifications established in the *FLTCIP 1.0 Benefit Booklet* in order to be certified and included in an approved plan of care.

If you have comprehensive coverage

Care in your home

Informal caregiver

An informal caregiver is a person providing maintenance or personal care whose services are not arranged or supervised by a home care agency. Informal care may be provided by a friend, relative, or private caregiver, as long as that person did not live in your home at the time you became eligible for benefits. Benefits for care provided by family members are limited to 365 days in your lifetime and are reimbursed at 75% of your daily benefit amount for both informal and formal caregivers. An employment agency may offer support in locating an informal caregiver, but it does not arrange for or provide supervision of care.

Required documentation

- A copy of a valid driver's license or passport, and a valid Social Security number are required for each informal caregiver.

Formal caregiver

A formal caregiver is a caregiver whose services are arranged and supervised by a home care agency (the caregiver is an employee of the agency). In addition, independent nurses and therapists may be used as formal caregivers. Other formal caregivers must meet the laws of the jurisdiction in which they are located in order to be included in an approved plan of care.

Required documentation

- A copy of the state-issued license for the appropriate type of home care agency and a Federal Employer Identification number are required.
- We will make reasonable attempts to obtain this information directly from the home care agency or other formal caregiver. However, we may ask for your assistance if we are unsuccessful in getting the information.

Care in a facility

A facility may be an adult day care center*, an assisted living facility, a nursing home, or a hospice facility. Facilities must meet the laws of the jurisdiction in which they are located in order to be included in an approved plan of care.

**Please note that adult day care centers are only reimbursed up to the home care rate of 75% of your daily benefit amount.*

Required documentation

- A copy of the state-issued license for the appropriate facility and a Federal Employer Identification number are required. The facility must also complete the appropriate facility form.
- We will make reasonable attempts to obtain this information directly from the facility. However, we may ask for your assistance if we are unsuccessful in getting the information.

2 Identify caregivers (continued)

If you have facilities-only coverage

A facility may be an assisted living facility, a nursing home, or a hospice facility. Facilities must meet the laws of the jurisdiction in which they are located in order to be included in an approved plan of care.

Required documentation

- A copy of the state-issued license for the appropriate facility and a Federal Employer Identification number are required. The facility must also complete the appropriate facility form.
- We will make reasonable attempts to obtain this information directly from the facility. However, we may ask for your assistance if we are unsuccessful in getting the information.

In order to avoid reimbursement denial or delays, all required documentation must be received and in good order before a provider can be added to an approved plan of care.

3 Meet the waiting period

Satisfy your plan's waiting period

Your waiting period is similar to a deductible in other insurance plans. The length of your waiting period is shown on your current schedule of benefits and is either **30 or 90 service days**. Service days are days during which you must be eligible for benefits and receiving and paying for care (care must be approved by your care coordinator) before we will pay for covered charges you incur for long term care services. Some benefits are paid during your waiting period such as hospice care, respite services, and caregiver training. Days applied toward satisfying your waiting period need not be consecutive, nor associated with the same episode of care.

You only have to satisfy your current plan's waiting period once in your lifetime.

In order to satisfy your waiting period, you must submit invoices following the guidelines on page 7. Once you satisfy your waiting period, you will be eligible for reimbursement of approved care expenses for services received after your waiting period if you continue to be eligible for benefits at that time.

Hospice care, respite services, and caregiver training

The waiting period does not apply while you are receiving hospice care, respite services, or caregiver training. We will pay for these services, however, they do not count toward meeting your waiting period. If, at any point, you are no longer approved for these services, benefits for other covered services will not be payable until the waiting period is satisfied.

Notification that the waiting period has been met

If your plan of care includes services that are subject to a waiting period, we will send you written confirmation once you have satisfied the waiting period indicating the date you are eligible for reimbursement of covered services and the date your waiver of premium will begin. Additionally, if you have an online account, it will be updated to indicate that your waiting period has been met.

Waiver of premium

You will not have to pay your premium once you have satisfied your waiting period. We will also waive your premium if you are eligible for benefits and receiving hospice care. If you satisfy the requirements for the waiver of premium on the first day of a month, the waiver will take effect on that date. Otherwise, the waiver will take effect on the first day of the following month.

4 Submit invoices and receive reimbursement

Submit invoices

You need to submit invoices to satisfy your waiting period. Once your waiting period has been satisfied, you may be reimbursed for services that are part of your approved plan of care. Please be sure to notify us of any requested changes to your plan of care in order to avoid denial of reimbursement or processing delays.

The reimbursement process for expenses paid by you depends on where you receive long term care and who provides that care. Therefore, in order to help you be reimbursed as quickly and accurately as possible, the following chart shows the requirements for submitting invoices by different types of providers.

Please submit your request for reimbursement by one method only. Duplicate submissions of the same invoice will delay claims processing. Invoices may be submitted by email to **claimsinfo@ltcfeds.gov,** by fax to **1-866-513-2674,** or by mail to **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797**.

Invoice submission

Informal caregiver (for comprehensive plans)

If you use an informal caregiver, you must submit the following documentation:

- Informal Caregiver Invoice (included in this brochure)
- proof of payment:
  - canceled personal, business, substitute, or cashier's checks; eStatements; money orders; online bill pay; or payroll payments
  - must be paid after services are rendered
  - payments made by cash or checks made out to cash are **not** reimbursable

Formal caregiver (for comprehensive plans)

If you use a formal caregiver (home care agency or other formal caregiver) or adult day care center, you must submit an itemized invoice that includes the following:

- the complete name, address, and phone number of the agency or adult day care center
- the individual dates of service
- the total hours per day
- the total charged per day
- a description of services provided
- the total amount charged per invoice

4 Submit invoices and receive reimbursement (continued)

Facility (for comprehensive and facilities-only plans)
If you use an assisted living facility or nursing home, you must submit an itemized invoice that includes the following: ▸ the complete name, address, and phone number of the facility ▸ the individual dates of service ▸ a description of services provided ▸ the total charged per type of service ▸ the total amount charged per invoice

Reimbursement requirements
▸ services have been rendered ▸ completed invoices have been received (submitted by you or the facility) ▸ providers and services match the approved plan of care ▸ reimbursement occurs after the last service has been provided (typically within five business days)

Payment of benefits

We pay benefits using the expense-incurred method. This method reimburses you for actual charges you incur for covered services received up to a specific dollar amount. We only pay for services based on invoices that are submitted directly to us.

Payments are either issued by electronic funds transfer (EFT) to your bank account or by check mailed to you. To initiate claims payments via EFT, please complete the Claimant Authorization of Claims Payments via Electronic Funds Transfer form on page 14. This form should be returned with a voided check.

Each time a payment is made for service provided for your care, an explanation of benefits is mailed to you and is available within your online account for your review. You will typically receive reimbursement within 10 days after all required documents have been received.

Assignment of benefits

Please note: An assignment of benefits is only available for home care agencies and facilities within the United States.

Payments are usually made to you, the claimant, for expenses incurred. However, claimants have the option to request direct payment to certain home care agencies or facilities. With this option, called assignment of benefits, invoices are submitted directly to FedPoint by the provider, and payments are made directly to the provider. To select this option, you must complete the Assignment of Benefits Form found on page 12. You may want to verify with your provider if they accept an assignment of benefits. We assume no responsibility for the validity or sufficiency of any assignment.

If your provider would like to be reimbursed by EFT, please offer them the Provider Authorization of Claims Payments via Electronic Funds Transfer form on page 16. This form should be returned with the completed Assignment of Benefits and W-9 forms.

Advanced billing

Some providers bill for services before they have been incurred. This is commonly referred to as advanced billing and is only allowed for services rendered in a nursing home or an assisted living facility. If a facility does bill in advance, payments are not made until after the first of the following month (e.g., if an August bill is received on August 15, it will not be processed until after September 1).

Informal Caregiver Invoice

Instructions

1. Enter the insured's claim ID and name, as well as the informal caregiver's name.
2. Enter one date of service per line.
3. Complete the time in and time out for that calendar day. Include a.m. and/or p.m., and round time to the nearest quarter hour.
4. Enter the total hours, approved hourly charge (per plan of care), and daily total for each date of service.
5. Enter the total reimbursement amount requested.
6. Mark an "X" in the correct box for each activity of daily living service provided per line.
   - Please note: *Eating* refers to providing assistance with getting food into the insured's mouth or assistance with a feeding tube or intravenous feeding. It does not mean providing assistance with meal preparation.*Transferring* means providing assistance with getting out of a bed, chair, or wheelchair. It does not mean providing transportation to the insured.
7. Enter the check or transaction number that corresponds with each date of service and attach the appropriate proof of payment. Accepted proof of payment includes:

Canceled personal, business, substitute, or cashier's checks

The following is required:

- image of the front and back of the check
- bank name and routing number present on the front of the check
- valid bank stamp (ink imprinted and/or electronic)
- substitute checks must also include a disclosure statement indicating that the check is a legal copy of the original

Please note: We do not accept carbon copies or duplicate checks, copies of uncashed checks, or copies of check registers as proof of payment.

eStatements and online bill pay receipts

The following is required:

- bank name or logo
- payee name
- remitter name
- posted or cleared date
- check number (this does not apply to electronic funds transfers or wires)
- payment amount
- corresponding reduction in account balance (this does not apply to online bill pay receipt)

Money orders or payroll payments

- In all cases, payment must be made after services are rendered.
- Payments made by cash or checks made out to cash are not reimbursable.
- The invoice total and proof of payment amount must match.

8. The informal caregiver must sign and date the invoice after services are rendered.
9. The insured or the insured's legal representative must sign and date the invoice after services are rendered.
10. If the informal caregiver and legal representative who sign the form on behalf of the insured are the same person, then an additional signature is required by a third-party to attest to the services rendered, hours worked, and payment made. **Note:** Handwritten signatures are required.
11. Visit **LTCFEDS.gov** to download more invoices.

Please return your completed invoice and proof of payment by email to **claimsinfo@ltcfeds.gov,** by fax to **1-866-513-2674,** or by mail to **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797**.

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The Federal Long Term Care Insurance Program™

Informal Caregiver Invoice

Claim ID

Insured's name

First name M.I. Last name

Informal caregiver's name

First name M.I. Last name

Informal caregiver's relationship to the insured

Date (mm/dd/yy)	Time in (indicate a.m. or p.m.)	Time out (indicate a.m. or p.m.)	Total hours	Approved hourly charge	Daily total
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

Description of services provided:

☐ Bathing ☐ Dressing ☐ Toileting ☐ Supervision/safety
☐ Continence ☐ Eating ☐ Transferring ☐ Other _____

Total paid $

Amount to reimburse $
☐ Taxes included
☐ Partial

Check or transaction numbers: _____

☐ **I have enclosed proof of payment (outlined on the back of this invoice).**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Sign and date after services are rendered.

Informal caregiver's signature

_____ **Date signed** ____ / ____ / ____
(Required) (Required: mm/dd/yyyy)

Insured's or legal representative's signature

_____ **Date signed** ____ / ____ / ____
(Required) (Required: mm/dd/yyyy)

Additional signature

_____ **Date signed** ____ / ____ / ____
(Required: mm/dd/yyyy)

If there is more than one legal representative that must act jointly, then all representatives must sign.

Assignment of Benefits Form

Insured's name

First name | M.I. | Last name

This Assignment of Benefits (AOB) form is used to assign benefits directly to your provider.* Once your plan of care has been established, you may submit the completed form. Your provider must also complete and submit the attached W-9 form. Only one AOB form and one W-9 form are required per provider per claim.

The AOB ends when the claim ends. If a new claim is opened, a new AOB form must be submitted after a plan of care has been established. In order to cancel an AOB, a letter, signed by the insured or the insured's legal representative, must be submitted requesting that reimbursement be issued to the insured.

***An AOB is only available for home care agencies and facilities within the United States.**

Provider information (where payment is to be sent)

Facility/agency's or provider's name

Federal Employer Identification number

Payment address

City | State

Zip | Phone number

Assignment of Benefits

I authorize payment to be paid to the provider shown above for long term care insurance benefits otherwise payable to me. I understand I am financially responsible to the named provider for the charges not paid or payable under the Federal Long Term Care Insurance Program. I understand that FedPoint may not be able to honor this request. If they cannot, they will pay the benefits directly to me as the insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I certify that the information furnished in support of this claim is true and correct.

Note: A handwritten signature is required.

Signature (insured or legal representative)

_____ **Date signed** ____ / ____ / ____

(Required) (Required: mm/dd/yyyy)

Please return your completed AOB and W-9 forms by email to **claimsinfo@ltcfeds.gov,** by fax to **1-866-513-2674,** or by mail to **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797**.

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Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** **Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

Claimant Authorization of Claims Payments via Electronic Funds Transfer

This form is for individual claimants to authorize the initiation of direct deposit of claims payments via electronic funds transfer (EFT) to a bank account or to change bank account information for an existing authorization. This form is only for individual claimants; providers who wish to establish direct deposit must use the Provider Authorization of Claims Payments via Electronic Funds Transfer form, which is available at **LTCFEDS.gov**.

Claimant's information

First name | M.I. | Last name

Social Security number

I authorize FedPoint to electronically credit my account and, if necessary, electronically debit my account to correct erroneous credits. I agree that the Automated Clearing House transactions I authorize comply with all applicable law. I understand that the insured individual who is collecting benefits through the Federal Long Term Care Insurance Program (FLTCIP) must be named on the bank account provided for direct deposit.

Banking information

Financial institution's name

Account type: ☐ **Checking** ☐ **Savings**

Routing number | Account number

With the submission of this form, please provide a voided check from the account listed above that includes the account holder's name.

I understand that I may revoke this authorization at any time by notifying FedPoint in writing at **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797**. FedPoint requires notice of at least five business days in order to cancel this authorization. In the event I cancel direct deposit of claims payments, future claims payments will be made via paper check.

Note: A handwritten signature is required.

Signature (claimant or legal representative)

(Required) **Date signed** ____ / ____ / ____ (Required: mm/dd/yyyy)

Please return your completed authorization form and a voided check by email to **claimsinfo@ltcfeds.gov,** by fax to **1-866-513-2674,** or by mail to **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797**.

A011C v. 3 0924 The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, under a group long term care insurance policy, and administered by FedPoint®. FedPoint is the trade name of Long Term Care Partners, LLC®.

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Provider Authorization of Claims Payments via Electronic Funds Transfer

This form is for providers to authorize the initiation of direct deposit of claims payments via electronic funds transfer (EFT) to a bank account or to change bank account information for an existing authorization. This form is only for providers; individual claimants who wish to establish direct deposit must use the Claimant Authorization of Claims Payments via Electronic Funds Transfer form, which is available at **LTCFEDS.gov**.
Payments will only be made directly to providers when a claimant has assigned benefits to the provider. If no such assignment of benefits is in effect, any claims payments will be made directly to the claimant.

Provider's information

Name

Address

City

State

Zip

Phone number

Taxpayer identification number (TIN)

Does this EFT apply to this location only, or to all entities under this TIN?

☐ This location only ☐ All entities

I authorize FedPoint to electronically credit my account and, if necessary, electronically debit my account to correct erroneous credits. I agree that the Automated Clearing House transactions I authorize comply with all applicable law and are bound by the NACHA Operating Rules.

Banking information

Financial institution's name

Account holder's name

Account type: ☐ Checking ☐ Savings

Routing number

Account number

Is this a corporate bank account? ☐ Yes ☐ No

continued on reverse side

Provider Authorization of Claims Payments via Electronic Funds Transfer

I understand that I may revoke this authorization at any time by notifying FedPoint in writing at **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797**. FedPoint requires notice of at least five business days in order to cancel this authorization. In the event I cancel direct deposit of claims payments, future claims payments will be made via paper check.

Note: A handwritten signature is required.

Signature (the signatory must be authorized to act on behalf of the provider)

_____

(Required)

Printed name

Title

___ – ___ – ____

Phone number

Date signed ____ / ____ / ____

(Required: mm/dd/yyyy)

Please return your completed form by email to **claimsinfo@ltcfeds.gov**, by fax to **1-866-513-2674**, or by mail to **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797**.

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5 Maintain the continuation of your claim

In addition to continuing to complete and submit invoices following the processes on page 7 of this brochure, you can help us provide you with timely reimbursements by:

Keep your plan of care up-to-date

- Inform us of any anticipated or actual change in your condition, care, or caregivers, and/or anticipated stay-at-home needs (such as home modifications and durable medical equipment) as soon as you know about or need to make a change. Any requested change to your plan of care must be reviewed and approved by our care coordination staff prior to making the change in order to avoid reimbursement denials or delays.
- Your care coordinator will contact you periodically to review your current needs and the existing plan of care.

Participate in the reassessment of your benefit eligibility

It is not uncommon for an enrollee to enter claim, recover, and enter claim again in later years. Because conditions can change with time, we regularly monitor each claimant's eligibility status throughout the claims process. While you are receiving care, we will review your eligibility for benefits at least once every 12 months and sometimes more frequently depending on your specific condition(s). It is your responsibility to notify us if your condition changes.

We may request additional information by: contacting you, your physician, or other persons familiar with your condition; accessing your medical records; having you examined, at our expense, by a licensed health care professional; and/or conducting an on-site assessment.

If long term care eligibility criteria can no longer be documented, a claimant is determined to be "recovered" and therefore no longer eligible for reimbursement benefits for the current claim. If you wish to maintain your coverage, you will have to resume paying your premium on the first day of the month following the month in which you are no longer eligible for benefits.

If you recover during your waiting period, any waiting period days accumulated will be applied to any future instances of becoming benefit eligible.

Contact us

If you have a question about your care or your coverage with the FLTCIP, please call **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 711 or email **claimsinfo@ltcfeds.gov**. Be aware that any time we speak to you or your approved authorized representative about specific health information or coverage, we are required to verify your identity by asking for personally identifiable information through our security process.

Calling FedPoint

When you call our toll-free number, you will reach one of our Customer Service claim services consultants (CSC), who are trained to support our care coordination and claims process.

Each time, the CSC will ask you to verify three facts:

- your claim ID, your unique ID, or your Social Security number (or last four digits)
- your date of birth
- your address

This security check is required to protect your health information. Without it, Customer Service will not be able to provide support or refer calls.

Once the security check is successfully completed, the CSC will ask how they may assist you. Many questions can be answered by the CSC. If you need to speak directly to your care coordinator or if you are returning your care coordinator's call, the CSC will provide you with instructions.

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