Explanation of Claims Topics

Medical records	Medical records are requested from your health care provider. At times, the provider may not send us complete records, or send the records in a timely manner, which may cause a delay in the benefit eligibility decision or recertification. We may make additional requests based on information we received that may help determine your eligibility for claims.
Care coordinator	Care coordinators are licensed nurses or social workers at FedPoint who are experienced in long term care. They will manage your claim and work with you to develop your plan of care. You may receive a claims satisfaction survey asking you about the service level of a care coordinator.
Calling 1-800-LTC-FEDS	When you call our toll-free number, you will reach one of our Customer Service claim services consultants, who are trained to support our care coordination and claims process. They are qualified and well-versed in answering your questions regarding your coverage and policy provisions, your invoice reimbursement, and the status of your claim. They do not provide support for clinical or medical information, or other nurse related issues. If you need to speak with your care coordinator directly or if you are returning your care coordinator's call, the claim services consultant will provide you with instructions.
Assessment	Our assessments are performed by a vendor registered nurse (RN), who is different from our care coordinators who manage your case. The vendor RN will contact you directly to schedule a time that is convenient for you. We recommend that you have another person with you at the time of assessment. The assessment may be completed onsite at your place of residence or virtually, depending on the situation. The length of an assessment is about 1.5 hours. The vendor RN only has the information that you provide on the form. This vendor RN is objective and has no knowledge about your policy or your medical history. The information collected is provided to FedPoint for consideration in their decision. Your tax-qualified policy requires reassessment at a minimum of every 12 months.
Plan of care	The plan of care (POC) identifies ways of meeting your needs for qualified long term care services. It will include details such as approved providers, dates and hours of service, hourly rates for caregivers, and quantified time for specific care services. Your plan of care is also used to validate invoices we receive for reimbursement. It is different from what you see in a hospital, nursing home, assisted living facility, and other providers where the POC is medical in nature. All caregivers must meet the requirements stated in your benefit booklet to be approved and added to your POC. Any change to your plan of care must be reviewed and approved by our care coordination staff prior to you making the actual change in order to avoid reimbursement denials or delays. It is important that you notify us of any changes to your care.
Legal representative	If you have a legal representative, we will review submitted documentation and inform you if the documents are in good order. Once accepted, your legal representative will be able to make changes on your behalf as you authorized in the legal representative documentation. If your condition involves the potential of a cognitive decline, you may want to consider establishing a legal representative.
Waiting period	The waiting period is the number of days during which you must be eligible for benefits before we will pay benefits for covered charges you incur for long term care services. The number and type of day is dependent on your FLTCIP coverage. Please refer to your benefit book and schedule of benefits for your specific requirements.

Explanation of Claims Topics

Submitting documents	All the required forms found in your Claims Information Kit must be completed and returned to us before we will open your claim. It's important to verify that all questions have been answered and that signatures are made by you, the insured, or by your legal representative. However, if you wish to authorize someone to make decisions on your behalf, the designated person must be so authorized in your durable financial power of attorney or guardianship papers. Once we process this legal documentation, your representative will then have the ability to complete forms related to your claim. When you send documents via mail, email or fax, please be sure to provide identification on every page. This may include your claims ID or unique ID, along with your name. All completed documents must be entered into our system, so it may take two to three days after we receive a document for us to confirm receipt.
Claim payments	We reimburse for actual charges you incur for covered services received up to a specific dollar amount. We will only pay for invoices submitted directly to us. Invoices must be filled out completely, and we must receive all necessary certification requirements. Providers and services must match those on your plan of care. All services must have been rendered; we do not pay for care in advance.
Informal caregivers	We require copy of the Social Security number and a photo ID (such as a driver's license) for review and approval. Once approved, they will be added to your plan of care.