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

Invoice Submission and Reimbursement Package

Thank you for your participation in the Federal Long Term Care Insurance Program (FLTCIP). This *Invoice Submission and Reimbursement Package* includes information for submitting requests for reimbursement. It also contains the important forms you, the insured, or your legal representative, must complete and return to us before we can process the reimbursement for approved care expenses.

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®.

FEDPOINT®

This brochure refers to FedPoint as "us," "we," and "our." Definitions of capitalized words within this brochure can be found in your *FLTCIP 1.0 Benefit Booklet*.

You can now request reimbursement for claims online.

Log into or create your My LTCFEDS account at **LTCFEDS.gov/login** and go to your Claims dashboard to manage your claim online.

From the navigation menu, select “Claims” then “Request Reimbursement” to provide required documentation to us in real-time so we can begin processing your request today:

- Upload invoices for care received from a Formal Caregiver or in a facility.
- Track the dates and times an Informal Caregiver provided services in your home.
- Upload proofs of payment made to an Informal Caregiver.
- Check the status of your reimbursement requests any time, 24/7.
- Get access to your explanation of benefits (EOBs) in one secure, convenient location.

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

Submit invoices and receive reimbursement

Once your waiting period has been satisfied, you may be reimbursed for services that are covered in your approved Plan of Care. Please be sure to notify us right away of any requested changes to your Plan of Care to avoid denial of reimbursement or processing delays.

If you have a legal representative who is authorized to make decisions on your behalf, please submit a copy of your durable power of attorney (DPOA) or guardianship papers (as your state requires). You don't have to wait until you need a DPOA. The sooner we have it on file, the better.

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

The fastest and most secure method for submitting invoices is through your My LTCFEDS online account. There, you can track your real-time invoice status from the time you submit until a payment is made.

Please submit your request for reimbursement **by one method only**. Duplicate submissions of the same invoice will delay claims processing.

Submit an invoice online by provider type

1. Log into your My LTCFEDS account.
2. Select "Claims."
3. Select "Request Reimbursement" and select a provider from the drop-down menu.
4. The selected provider will determine the provider type (e.g., informal, formal,or facility).
5. Follow the next steps by provider type below.

Informal Caregiver

If you use an Informal Caregiver (including an approved family member), follow these instructions:

1. Indicate what Activities of Daily Living were provided.
2. Enter the dates and times for each service. (You can either save entries one at a time or enter multiple dates of service at once.)
3. Indicate if you withheld taxes or if you want to include reimbursement of employer taxes, then enter the amount.
4. Review the invoice summary, upload proof of payment, complete the acknowledgment, and submit for reimbursement.

continued on next page

Formal Caregiver

If you use a Formal Caregiver (e.g., a Home Care Agency) or a Hospice agency, follow these instructions:

1. Answer each question on the Formal Caregiver screen, including the date range of services and total amount due.
2. Upload the invoice from the Formal Caregiver, complete the acknowledgment, and submit for reimbursement.

Facility

If you use an Assisted Living Facility, Nursing Home, or Hospice facility, follow these instructions:

1. Answer each question on this screen, including the date range of services and total amount due.
2. Upload the facility invoice, complete the acknowledgment, and submit for reimbursement.

Reimbursement requirements

The following are required for reimbursement:

- services have been rendered
- completed invoices have been received in good order (submitted by you, the facility, or Home Care Agency)
- providers and services match the covered services in the approved Plan of Care

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 specified benefit amount available. We only pay for services based on invoices that are submitted directly to us. You can have more than one service or caregiver on the same day; however, invoices are processed in the order they are received.

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 7. This form should be returned with a voided check, bank statement, or bank letter confirming your banking details. Most EFT payments are transferred to your bank account by the end of the sixth business day after the receipt of your invoice.

Each time a payment is made for service provided for your care, an explanation of benefits (EOB) is mailed to you and is available within your online account for your review. If you signed up for electronic EOB notifications, you will receive an email when it is available. You will typically receive an EFT reimbursement the same day you receive an EOB notification.

Assignment of benefits

Please note: The assignment of benefits is only available for Home Care Agencies and facilities within the United States. An assignment of benefits is not available for Informal Caregivers.

Payments are usually made to you, the claimant, for expenses incurred. However, you have the option to request direct payment to certain Home Care Agencies or facilities. Under this option, called assignment of benefits, invoices are submitted directly to us by the provider and payments are made directly to the provider. If your provider accepts an assignment of benefits, you must complete the Assignment of Benefits Form found on page 8. We assume no responsibility for the validity or sufficiency of any assignment.

An assignment of benefits is effective on the date it is processed and will be applicable to all invoices processed after that date.

If your provider would like to be reimbursed by EFT, they must complete the Provider Authorization of Claims Payments via Electronic Funds Transfer form on page 10. This form should be returned with the completed Assignment of Benefits and W-9 forms.

Billing at the beginning of the month

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/planning-tools/resources** to download more invoices.

You may return your completed invoice and proof of payment online at **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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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/yyyy)	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.

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

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, the trade name for Long Term Care Partners, LLC, 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

For checking accounts, you must provide a voided check from the account listed above that includes the account holder's name.

For savings accounts, you must provide a bank statement from the account listed above or bank letter confirming your banking details.

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 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)

Printed name

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

The Federal Long Term Care Insurance Program™

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. 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 (FLTCIP). I understand that Fedpoint, the trade name for Long Term Care Partners, LLC, 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)

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

Printed name

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

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

The Federal Long Term Care Insurance Program™

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, the trade name for Long Term Care Partners, LLC, 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, the trade name for Long Term Care Partners, in writing at **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797**. FedPoint requires notice of at least five business days 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 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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Visit our Learning Center

We offer online educational resources for FLTCIP enrollees and their representatives to help you learn more about your coverage and the claims process. You can register in advance for our upcoming webinars or watch on-demand webinars and videos at your convenience. Visit **LTCFEDS.gov/webinar** today.

Contact us

If you have a question about your FLTCIP coverage, please log into your **My LTCFEDS account** on **LTCFEDS.gov**. There, you can review your coverage, your current claim, and any previous claim. If you need more assistance, email **claimsinfo@ltcfeds.gov** or call **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 711. Be aware that any time we speak to you or your legal representative about specific health information or coverage, we are required to verify your identity by asking for personally identifiable information through our security process.

Call 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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