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

Appeal Initiation Form

If we initially deny your eligibility for benefits or your claim and then, on review, we uphold our denial, the Federal Long Term Care Insurance Program (FLTCIP) provides an appeal process.

If you choose to appeal our eligibility for benefits or claim decision, you must send a written request to us, including any additional information you wish to have us consider, no later than 60 days after the date of our review decision. This form is used to initiate the appeal process.

You can't appeal decisions that are based on the *FLTCIP Benefit Booklet*'s rules. If this occurs, we will send you a written notice explaining that this is not considered an appeal. For example, you can't appeal a denial of your claim for benefits for Nursing Home services because you exhausted your Maximum Lifetime Benefit.

The appeals committee will provide you with a notice of its final decision no later than 60 days after the date we receive the completed form.

Before you submit this request, please review the criteria for benefit eligibility and claim determination in your *FLTCIP Benefit Booklet*.

Insured information

First name | M.I. | Last name

Unique ID or claim number

Address line 1

Address line 2

City | State/territory

Country | Zip/foreign postal code

Home phone – – | Date of birth (Month/Day/Year) / /

Work phone – –

Email

Reason(s) for appeal

Select the reason for this appeal. ☐ Denial of benefit eligibility ☐ Denial of a claim payment

State the specific reason you disagree with FedPoint's prior decision.

Provide any factors or relevant clinical details that support your reason(s) for appeal. Be as specific as possible and include or refer to dates or documents that may assist us in our review.

Continued

Agreement and acknowledgment

I am requesting an appeal of a FLTCIP benefit eligibility or claim decision regarding the reason listed above. All of the answers and explanations I have provided herein are accurate and complete to the best of my knowledge and ability. I understand that medical records and answers to any questions that a care coordinator may have will also be considered by the FLTCIP as part of its review of this appeal request.

If there are any changes to my health, treatment, or provider, I agree to immediately notify the FLTCIP in writing using the contact information below.

Warning: Any person who, with an intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties.

Before we can process your request, you must certify by signing below that the information you have provided on this form is accurate and complete to the best of your knowledge and ability.

Signature (insured or legal representative)

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

Check the correct box: ☐ Insured ☐ Legal representative

Printed name

Note: If this appeal request form is signed by someone other than the insured, a copy of the durable power of attorney or guardianship papers may be required.

Please return your completed form by email to **claimsinfo@ltcfeds.gov** or by mail to **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797**. Email is the quickest option because it reaches us immediately and allows us to begin processing your request without delay.