The Federal Long Term Care Insurance Program™

Provider Supplemental Verification Form

This form is for providers to submit with each request for reimbursement if such invoice does not already give answers to the questions listed on this form. All information must be legible, including patient and provider demographics. There may be a delay in processing your request for reimbursement if any of the relevant information is missing or unclear on this form.

Resident's name _____ Unique ID or claim number _____

1. Billing period (attach invoice) From ____ / ____ / _____ To ____ / ____ / _____

2. Total amount requested for reimbursement: _____

Please indicate if the resident is primary or secondary.

☐ **Primary resident charges**

Room and board _____

Level of care _____

Ancillary charges _____

☐ **Secondary resident charges**

Room and board _____

Level of care _____

Ancillary charges _____

3. If credits are listed on the invoice, provide the date and a description for each credit.

Date	Credit	Description

4. Was the resident absent from the facility overnight at any time during this billing period? ☐ **Yes** ☐ **No**

Hospital stay Admission date ____ / ____ / _____ Discharge date ____ / ____ / _____

Overnight absence Departure date ____ / ____ / _____ Return date ____ / ____ / _____

5. Is Medicare A or Medicaid providing benefits for services during this period? ☐ **Yes** ☐ **No**

Dates of Medicare A coverage From ____ / ____ / _____ To ____ / ____ / _____

Dates of Medicaid coverage From ____ / ____ / _____ To ____ / ____ / _____

6. Is another insurance plan or the U.S. Department of Veterans Affairs (VA) providing benefits for services during this period?

☐ **Other insurance.** The explanation of benefits amount paid is: _____

☐ **VA.** The amount covered is: _____

7. If your facility has multiple levels of care, in which section does the resident reside?

☐ **Skilled nursing** ☐ **Assisted living** ☐ **Independent** ☐ **Other**

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

Note: A handwritten signature is required.

Provider's name _____ Title _____

Signature _____ Date ____ / ____ / _____

Phone _____ Email _____

Please return your completed form and additional materials 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**.