Claim Tips for adult children or advocates of a loved one who has LTC insurance

1) Before contacting the insurance company, make sure that you know the policy number. If it's not readily available, ask the insurance company if the policyholder's social security number will suffice.

2) Contact the Claims Department in the event of a potential claim. Customer Service is typically responsible for billing questions. You will be required to have HIPAA access in order to obtain any information about the policy. They will mail a claim form, but won't discuss details of the policy without the policyholder's permission ***unless you have power of attorney***. Ask the Claims Department if they require a written signed form to gain HIPAA access, or can the policyholder give verbal permission over the phone (assuming there is no cognitive impairment) for them to speak with you about the policy.

3) If the adult child or advocate does have Power of Attorney, a copy of the document will be required by the insurance company.

4) Once HIPAA access has been granted, the adult child, advocate, or policyholder (if well enough) should inquire of the Claims Department:

    a. What is the daily or monthly benefit?
    b. How many years of benefit are available for care, or what is the *pool of dollars* available for care?
    c. Can 100% of the benefit be used for care at home or at an Assisted Living Facility? If the benefit is used for home care, whom can be hired? Through an agency or professional care provider? Through a non-licensed, independent care provider?
    d. **Most policies will have an Elimination Period that must be satisfied before benefits will be paid. Ask the representative to carefully explain the details about how to satisfy the Elimination Period**.
    e. What kind of policy is it?
        i. Is it a reimbursement policy whereby a check is sent to the policyholder or POA representative after receipts are submitted? Or,
        ii. Is it an indemnity policy whereby a check is sent each month once the claim is approved, with no receipts required?

5) Typically the claim form will have a section for the claimant's physician to complete, as well as a corresponding section for either the policyholder or someone else close to him/her to complete stating why it's believed a claim should be made. Remember the definition for triggering a tax qualified policy is: ***the policyholder is unable to perform 2 out of 6 Activities of Daily Living (bathing, feeding, dressing, toileting, continence or transferring - such as from a bed to a chair) along with the expectation that assistance will be needed for at least 90 days.... OR, that there is a severe cognitive impairment.*** *(LTC insurance policies sold many years ago may have only covered a nursing home and may have different triggers for paying benefits.)*

Meredith Pensack, CLTC **617-332-5901**
Long-Term Care Insurance Planning Specialist **mpensack@ltciplanning.com**

6) A common reason that the insurance company may delay responding to the claim is that the physician's office didn't forward the physician's claim section back to the insurer. The adult child or advocate can check in with the physician's Office Manager to obtain the date it was sent, or request that it be sent as soon as possible. The Claims Department should eventually be able to confirm that all necessary paperwork has been received and provide a time frame as to when a response will be provided.

7) Usually a representative on behalf of the insurer will make contact to set up an in-person interview. This person is typically a nurse, and may be called a "care coordinator". The representative is there to observe the policyholder and ask questions about limitations. It's important that a competent loved one be physically present for that meeting to advocate as to why the claimant needs assistance, tying back to the 2/6 Activities of Daily Living being deficient OR pertaining to a significant cognitive impairment. It's also important that the claimant triggers this definition and the nurse observes this or understands the limitations. If the policyholder is a fall risk and has fallen in the past this should also be communicated. Cognitive exercises will be given, and if that's the primary reason for making a claim the policyholder shouldn't be able to pass this, proving an inability to function at even a moderate level of cognition. The policyholder's advocate should observe the performance on the exam.

8) The representative will complete a report with details about the visit and submit it to the Claims Department. Once a claim is approved, the Claims Representative can discuss/forward their form for care receipts. If care is being received in a facility, you can ask if the payment can go directly to the facility, if desired. If care is received at home, it's important to save all receipts from the beginning. Frequently they'll reimburse retroactively for expenses. It may also be possible to have a home care agency deal directly with the insurance company if both the agency and the insurance company agree.

9) During the process of inquiring about a potential claim, if you would like to speak to an agent of the insurance company, find out if the original agent that sold the policy is still available. If not, and if the insurance company is still selling new LTC policies, they may be able to assign you a new agent to speak with as a courtesy. This person is a volunteer and may be helpful in answering any additional questions you may have.

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