CalPERS Long-Term Care Program

CLAIM INTAKE PACKET

Thank you for contacting CalPERS Long-Term Care Program regarding your recent request for benefits. Attached is a Claim Intake Packet. The enclosed Information Page explains what forms must be completed and submitted in order to proceed with your claim request.

In order to determine your eligibility for benefits, we require that an in-person assessment be performed. The assessment, if required, will be performed by a care advisor. If you have not already received a call, they will be calling you shortly to arrange for an in-person assessment interview at a time that is convenient for you. Your cooperation in scheduling this interview as soon as possible is greatly appreciated.

Your claim form and other required documents must be completed and returned in order to complete the processing your claim. If you recently submitted these documents to us, please disregard. You may return the completed forms to us via fax to 1-866-294-6967 (preferred) or mail them to CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164.

If you have any questions regarding this request, please call our Claims Representatives at 1-800-982-1775, between 8:00 a.m. and 6:00 p.m. Pacific Time, or e-mail us at calpersltc@illumifin.com.

Sincerely,

Claims Department
Illumifin – Administrator for CalPERS Long-Term Care Program

Long Term Care Group, Inc., the administrator for your long term care insurance carrier, has merged with illumifin Corporation (DBA in California: illumifin Administration) and has rebranded to illumifin.

CalPERS Long-Term Care Program

LONG-TERM CARE CLAIM FORM

Instructions: *The claim form is required to determine your eligibility for benefits. Please complete the form to the best of your knowledge. Please sign and return the completed form via fax to 1-866-294-6967 (preferred) or mail to: CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164.*

Section 1: Claim Contact Information

Claimant Name _____ Coverage ID Number xxx-xx-_____

Other name(s) known by _____ Date of Birth __/__/__ Last 4 of Social Security # _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ ❑ M ❑ F Gender

Contact Person Name* (if unable to reach claimant) _____

Phone Number _____ Relationship to Claimant _____

*******The above Contact Person must be either your attorney-in-fact or an Authorized Individual for whom you have submitted a **Third Party Authorization Form** for Use and Disclosures of Protected Health Information to an Authorized Individual.*

Do you have an attorney-in-fact (person to whom you have given Power of Attorney), court appointed Conservator, or Legal Guardian? ❑Yes ❑ No

If yes, attach a copy of the legal documents (Power of Attorney, Conservatorship, or Legal Guardianship) to this claim form. If you have appointed more than one person to represent you, provide information on the other person(s) on a separate sheet of paper.

Please note that in accordance with The Health Insurance Portability and Accountability Act (HIPAA), we will not disclose information to individuals who do not hold Power of Attorney, who are not Authorized Individuals or are not your guardian/conservator.

Section 2: Care Needs Information

What is the reason(s) or condition(s) resulting in your need for long-term care?

Please include date of occurrence/onset if applicable – if unknown, please estimate the onset of the condition

Date of occurrence/onset: _____

Description: _____

_____

_____

_____

_____

What other health conditions do you have that contribute to your need for assistance?

_____

_____

What best describes your current living situation?

Lives with:
- ❑ Alone
- ❑ Spouse/Significant Other
- ❑ Other: _____

Location:
- ❑ Private Home
- ❑ Independent Living Facility
- ❑ Assisted Living Facility
- ❑ Memory Care Unit/Facility
- ❑ Skilled Nursing Facility
- ❑ Hospital/Swing Bed
- ❑ Transitional Care/Rehabilitation Facility

Is there a spouse/significant other in claim? ❑ Yes ❑ No

Section 3a: Activities of Daily Living

Typical long-term care services are assistance with daily activities, like bathing, dressing, using the toilet, etc., or needing supervision due to a cognitive impairment.

*Indicate the **current level of assistance needed** with the following Activities of Daily Living (ADLs). Use the following guide to indicate the level of assistance being provided on a regular basis:*

- *1 = No assistance is provided, claimant is Independent*
- *2 = Uses equipment, does not receive assistance from another person*
- *3 = Receives cueing/prompting to initiate or complete the ADL due to memory loss*
- *4 = Receives stand-by assistance (person within arm's reach) from another person to complete the ADL*
- *5 = Receives hands-on assistance from another person to complete some or all of the ADL*
- *6 = Unable to participate in <u>any</u> part of the ADL*

ACTIVITIES OF DAILY LIVING	**Level** (use key above)	**Frequency**	**How do you complete activity when alone?**
Bathing		❑ Always ❑ Daily ❑ Occasional ❑ Weekly	
Dressing		❑ Always ❑ Daily ❑ Occasional ❑ Weekly	
Toileting		❑ Always ❑ Daily ❑ Occasional ❑ Weekly	
Transferring		❑ Always ❑ Daily ❑ Occasional ❑ Weekly	
Incontinence		❑ Always ❑ Daily ❑ Occasional ❑ Weekly	
Eating (does not include meal prep.)		❑ Always ❑ Daily ❑ Occasional ❑ Weekly	
Mobility/Ambulation (indoors only)		❑ Always ❑ Daily ❑ Occasional ❑ Weekly	

Describe in more detail what assistance you need with any activities marked above.

If durable medical equipment is used, please describe the type of equipment and when this is needed:

_____

_____

_____

Section 3b: Instrumental Activities of Daily Living (Homemaker Services)

Please fill out the section below if the policyholder is receiving assistance with any activities or tasks beyond basic care that allow the policyholder to live independently.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING	**Assistance Needed?**	**Comments**
Housekeeping	❑ Yes ❑ No	
Laundry	❑ Yes ❑ No	
Meal Preparation	❑ Yes ❑ No	
Medication Reminders	❑ Yes ❑ No	
Money Management	❑ Yes ❑ No	
Shopping	❑ Yes ❑ No	
Social Companionship	❑ Yes ❑ No	
Telephone Use	❑ Yes ❑ No	
Transportation	❑ Yes ❑ No	
Other _____	❑ Yes ❑ No	

Section 4: Cognitive Impairment

Only fill this section out if policyholder has a cognitive impairment. If claimant does not have a cognitive impairment, please check "No" and proceed to next page.

Does policyholder have cognitive impairment? ❑ Yes ❑ No ❑ Undetermined

If Yes, please fill in section below.

Is there a known formal diagnosis of cognitive impairment? ❑ Yes ❑ No ❑Undetermined

If yes, please list cognitive impairment diagnosis:_____

Date of diagnosis:_____

Has formal cognitive testing been completed? ❑ Yes ❑ No ❑ Undetermined

If yes, when was testing completed? _____

List any Dementia Medications:

_____

_____

_____

List any additional information related to the claimant's cognitive behavior:

_____

_____

_____

Section 5: Other Insurance Information

Only fill this section out if there is additional insurance coverage for payment of this claim. If no other coverage exists, please check "No Medicare coverage or Supplemental Insurance" and proceed to next page.

❑ No Medicare coverage or Supplemental Insurance

Medicare Insurance Type: ❑ Part A ❑ Part B ❑ Part D

Other Insurance for this Claim *(Please attach additional pages if necessary)*

❑ Medicare Supplemental Insurance/Medigap
❑ Health
❑ Other Long-Term Care Policy: ❑ Group ❑ Individual
❑ Veterans Affairs (VA)
❑ Medicaid or MediCal
❑ Liability insurance (automobile, homeowners, liability, workers' compensation, or disability insurance)

_____
Carrier Name

_____
Policyholder Name

_____
Address

_____
City State Zip Code

_____
Phone

_____ _____
Policy Number Coverage ID

_____ _____
Effective Date Expiration Date

Section 6: Third Party Liability

Has there been an injury, fall, fracture, or motor vehicle accident that resulted in filing a claim with another insurance carrier? ❑ Yes ❑ No

Section 7: Medical Provider and Hospitalization Information *(Please attach additional pages if necessary)*

Physician Information

Name of Physician _____ Specialty (if any) _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Physician Information

Name of Physician _____ Specialty (if any) _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Are you currently hospitalized, or have you been hospitalized within the last 6 months?

Hospital Name _____

Address _____

City _____ State _____ Zip Code _____

Admission Start Date _____ Admission End Date _____ Reason for Admission _____

Section 8: Service Provider Information *(Please attach additional pages if necessary)*
Please list any service providers that are or have recently provided long-term care services to you.

Check Provider Type:

❑ Home Health Agency/Home Care Agency
❑ Independent Living Facility
❑ Assisted Living Facility
❑ Skilled Nursing Facility
❑ Adult Day Care
❑ Hospice Facility
❑ Hospice Agency

Name of Provider

Address

City State Zip Code

Phone Fax

Date Services Started Date Services Ended

Check Provider Type:

❑ Home Health Agency/Home Care Agency
❑ Independent Living Facility
❑ Assisted Living Facility
❑ Skilled Nursing Facility
❑ Adult Day Care
❑ Hospice Facility
❑ Hospice Agency

Name of Provider

Address

City State Zip Code

Phone Fax

Date Services Started Date Services Ended

Check Provider Type:

❑ Home Health Agency/Home Care Agency
❑ Independent Living Facility
❑ Assisted Living Facility
❑ Skilled Nursing Facility
❑ Adult Day Care
❑ Hospice Facility
❑ Hospice Agency

Name of Provider

Address

City State Zip Code

Phone Fax

Date Services Started Date Services Ended

Section 9: Claim Fraud Warning Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are requesting a claim was issued.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR, LA, RI, TX and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE, FL, ID, IN and OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ and NM: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH and OR: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement material to the risk may be guilty of insurance fraud.

PA: 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.

PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Section 10: Signature Page

I declare that all of the answers given are complete and true to the best of my knowledge and belief. I understand that the company reserves the right to require further proof. By signing below, I agree that I have read and understand the applicable Claim Fraud Warning Statements.

_____

*Signature of Claimant or *Legal Representative* *Date signed (Month, Day, Year)*

_____

Printed Claimant's or Legal Representative's Name *Signed at (City, State)*

_____

If Representative, give relationship to Claimant

**If you are signing as a legal representative, describe the scope of your authority to act on the Individual's behalf and include a copy of the documentation of your legal authority.*

CalPERS Long-Term Care Program

AUTHORIZATION FORM

Instructions: *By signing this form, you are giving us authorization to obtain records from your provider to determine your eligibility for benefits. Please complete and return this form via fax to 1-866-294-6967 (preferred) or mail to: CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164.*

Claimant Name: _____
Claimant Date of Birth: _____
Coverage ID Number: _____

I AUTHORIZE THESE PERSONS or institutions having any records or knowledge of me or my health:

- Any physician, medical practitioner, or health care provider
- Any hospital, clinic, pharmacy or other medical or medically related facility, or association
- Any insurance company or insurance support organization
- Any employer or plan administrator
- Any government agency
- Any organization or entity administering a benefit program
- Any rehabilitation organization or program
- Any financial institution, consumer reporting agency, accountant, or tax preparer

TO GIVE THIS INFORMATION:

Chart notes, x-rays, operative reports, lab and medication records and all other medical information about me, including *medical history, diagnosis, examinations, testing and test results, prescriptions, prognosis and treatment of any physical or mental condition including:*

- Any disorder of the immune system including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes. **Note:** In the state of Minnesota, this Authorization does not include the performance of, or the results of, a test to determine the presence of the Human Immune Deficiency Virus (HIV) antibody given to (a) an offender, as defined under Minnesota law; or (b) a crime victim because of exposure to, or contact with, such an offender.
- Any communicable disease or disorder.
- Any psychiatric or psychological condition, including test results.
- Any condition, treatment, or therapy related to Substance Abuse, including Alcohol and Drugs; **and**
- Any non-medical information including such things as eligibility for other benefits, earnings, or finances.

TO CalPERS Long-Term Care Program:

- I understand that CalPERS Long-Term Care Program will use the information to determine my eligibility for benefits.
- CalPERS Long-Term Care Program may release information about me to its affiliates, or any person performing business or legal services for CalPERS Long-Term Care Program in connection with my claim. I ACKNOWLEDGE THAT I HAVE READ THE AUTHORIZATION and I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with CalPERS Long-Term Care Program. A photocopy of this authorization is as valid as the original.
- I may revoke this authorization at any time by providing written notice to CalPERS Long-Term Care Program.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of CalPERS Long-Term Care Program or protected by the privacy rules under the Health Insurance Portability and Accountability Act.
- I understand that I have the right to refuse to sign this Authorization, but if I do not sign the Authorization, CalPERS Long-Term Care Program will not be able to determine my eligibility for benefits.

_____

*Signature of Claimant or *Legal Representative* *Date signed (Month, Day, Year)*

**All signatures, other than that of the Claimant, must be identified and accompanied by appropriate documentation of authority to represent the Claimant (for example: Durable Power of Attorney, Conservator, or Guardian)*