5 Tips to Start a Long-Term Care Claim

CUSTOMER INSIGHTS

John Hancock wants your long-term care insurance claim experience to be as positive as possible. For that reason, we have compiled some tips about starting a claim based on feedback from our customers.

1 NOTIFY JOHN HANCOCK WHEN YOU BEGIN TO NEED CARE

The first step in the claim process is for John Hancock to certify that you meet the benefit eligibility criteria outlined in your policy. Depending on your situation, this can take anywhere from a few weeks to over a month. Most policies define the benefit eligibility criteria in terms of your ability to perform certain activities of daily living or your level of cognitive function. The exact criteria varies by policy, so you will want to review this section of your policy closely.

In order to make this determination, John Hancock will provide you with a claim form that asks you a few questions about your functional/cognitive status and asks for contact information for your care providers. Based on your individual situation, the review may also involve an onsite assessment in your home or obtaining records from your care provider(s).

In addition to verifying benefit eligibility, John Hancock will also verify that each long-term care service provider meets the policy criteria for a qualified provider. (See the claim process overview for more information.) The provider eligibility process can begin as soon as you start a claim. Notify John Hancock immediately when a new care provider is used to minimize any processing delays.

TIP

Don't wait! Contact John Hancock to start your claim as soon as you require long-term care assistance. You do not need to wait until you think you've met the Elimination Period.

2 REIMBURSEMENT DOES NOT BEGIN UNTIL THE ELIMINATION PERIOD* IS MET

Most people will not begin receiving reimbursement checks immediately upon starting a claim. There are usually some expenses for which the claimant is responsible, possibly for several months.

What is an Elimination Period? To help distinguish acute care from true long-term care needs, most long-term care insurance products contain an Elimination Period. Similar to a deductible on auto, home, or health insurance, you will not be eligible for reimbursement until you receive care for a certain number of days and/or dollars after you meet the benefit eligibility criteria.

The requirements of the Elimination Period (e.g., length, dollars spent, etc.) vary widely based on the type of product you have and the options you selected at time of purchase. There may even be some types of services that will be reimbursed during this Elimination Period. We recommend that you review this section of your policy closely to understand the specifics of your coverage.

TIP

Send in copies of all your outstanding bills as soon as you receive benefit eligibility approval. Services covered by Medicare may count toward your Elimination Period.

*Some products may refer to the Elimination Period as a Qualification Period or Waiting Period.

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3 KEEP COPIES OF ALL LONG-TERM CARE BILLS

Most coverage follows a Reimbursement Model – meaning, you incur certain long-term care expenses and then you are reimbursed for the actual charges (within coverage limits defined in your policy). As a result, you will need to provide documentation of the charges that are incurred. Documentation typically refers to a bill from your provider that outlines each date of service, the type of service provided, and the charge for the service.

Collect all documentation, even while you are awaiting your benefit eligibility certification. As soon as you receive approval, gather all your bills for long-term care services received to date and submit them to John Hancock for processing. This will ensure that you receive appropriate credit toward your Elimination Period as quickly as possible. Continue to submit bills regularly for credit/reimbursement.

Nursing Facility Bills: Many facilities bill in advance. While facility bills may be submitted in advance, payments will not be released until the end of the month.

Home Health Agency Bills: Some Home Health Agency bills only contain a summary of charges. In this case, you may also be asked to provide the daily logs that detail the type of care provided along with duration and charge detail. If you employ an Independent Care Provider rather than an agency, you will need to use an Independent Care Provider Service Bill provided by John Hancock after provider approval.

Medicare Charges: If your policy requires that you incur expenses to meet your Elimination Period, you may be able to receive credit for covered services that are paid by Medicare. You will need to provide copies of the Medicare UB04 forms and submit those for processing. The UB04 form is a document your provider uses to submit charges to Medicare. You may not always receive this documentation, so let your provider know right away that you will need copies of the UB04 statements. A Medicare Explanation of Benefits does not contain the detail needed to apply credit to your Elimination Period.

TIP

Unlike most health insurance where charges are automatically paid, you will need to submit bills to receive credit to your Elimination Period or reimbursement for long-term care expenses.

4 ALLOWING A FAMILY MEMBER TO MANAGE THE CLAIM

Many claimants prefer to assign a family member or advisor as the primary claim representative. In order for this person to assume full responsibility for the claim (filling out and signing forms, changing payment method, etc.), he or she will need to have financial power of attorney/guardianship (or the equivalent in your state). This does not typically include a health care power of attorney or health care proxy. John Hancock will need to receive authorization from the insured or power of attorney/guardian in order to discuss coverage or claim details with someone other than the insured.

TIP

Submit a copy of the Power of Attorney document to John Hancock as soon as possible to avoid any processing delays.

5 NOT ALL FACILITY TYPES ARE COVERED AT THE SAME LEVEL

Many policies make a distinction between a nursing facility, an assisted living facility, and an independent living facility. This can be especially confusing if your facility operates with multiple levels of care (i.e., a facility that has separate units for independent living and assisted living). Be sure to clarify with your provider the section in which you reside – it may change the level of reimbursement you receive. For example, your policy may cover nursing facility care and home health care, but since an Independent Living Facility (ILF) is not defined as a nursing facility, care at an ILF may only be covered for home health services/limits.

TIP

Check with your provider to determine the level of care for the section of the facility in which you reside.

For more in-depth details about the claims process, refer to the Process Overview and Frequently Asked Questions flyers on JHLTCClaims.com. Review your policy for specific details about your coverage.