

## Long-Term Care Insurance Claim Packet

Use these forms to file a Long-Term Care Insurance claim and have them completed as soon as possible after your claim begins.

### Instructions:

- 1. Claimant Statement** - You (or a person acting for you) must complete the Claimant Statement portion of this packet.
- 2. Provider Service Report** - A representative from each health care facility or agency from which you received care must complete the Provider Service Report portion of this packet. Make additional copies as needed. This form is also available on our website - Thrivent.com.
- 3. Attending Physician Statement/Plan of Care** - The physician who is primarily responsible for your care must complete the Attending Physician Statement/Plan of Care portion of this packet.
- 4. If you have a Durable Power of Attorney (DPOA) for Finances or a Guardian**, provide a copy of that document.
- 5. The claimant is responsible for charges incurred for the completion of these forms.**
- 6. Send the initial billing statements from each qualifying care provider. If your claim is approved, we will let you know in the approval letter if additional bills are needed.**

Return the completed claim form(s) and supporting documents to: **Long-Term Care Claims  
Thrivent  
PO Box 8075  
Appleton, WI 54912-8075  
or fax to 800-225-2264.**

Refer to your contract or rider for specific benefit information. If you have any questions concerning benefit eligibility, the completion of the enclosed forms, or the handling of your claim, we encourage you to call Long-Term Care Claims at 800-847-4836, say "directory" and enter extension 6283166.

# Long-Term Care Insurance Claim Packet

Thrivent ID

Contract number

## Claimant Statement

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Name of claimant

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Nature of sickness or injury

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☐ Yes   ☐ No   Is Medicare covering/has Medicare covered any of claimant's Long-Term Care services?

**If yes,** dates - \_\_\_\_\_

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Name of attending physician

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Phone of attending physician

---

Address of attending physician

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City

---

State

---

ZIP code

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Claimant is applying for:   ☐ Nursing home   ☐ Assisted living   ☐ Home care   ☐ Respite care  
☐ Independent living   ☐ Other (specify) - \_\_\_\_\_

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Date when facility confinement or services began - \_\_\_\_\_

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☐ Yes   ☐ No   Is claimant still receiving these services? **If no,** date when care ended - \_\_\_\_\_

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Name of home health care agency, nursing facility or provider of care, if currently being used or planned for use

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Date of admission

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Address

---

Phone

---

City

---

State

---

ZIP code

---

Name of previously used home health care agency, nursing facility or provider of care

---

Date

---

Address

---

Phone

---

City

---

State

---

ZIP code

## Claimant Statement (continued)

- ☐ Yes ☐ No Does someone hold a Durable Power of Attorney for finances document for the claimant?  
☐ Yes ☐ No Does someone hold a Guardianship document for the claimant?

**If yes**, list the Power of Attorney or Guardian below and attach a copy of this document.

**If no**, list the name of the person we can contact with questions.

|         |              |          |
|---------|--------------|----------|
| Name    | Relationship |          |
| Address | Phone        |          |
| City    | State        | ZIP code |

## Signature for Claimant Statement

**For your protection**, state laws require the following to appear on this form: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files or facilitates the filing of a statement of claim containing any materially false information, or conceals information concerning any fact material to the statement, may be guilty of insurance fraud, which may be a felony crime, subject to civil penalties or criminal prosecution, including substantial fines and/or confinement in prison.

|   |             |                         |
|---|-------------|-------------------------|
| Signature of person completing the form | Date signed | Relationship to insured |
| <b>X</b>                                |             |                         |

## Direct Deposit Authorization

|  |                |   |          |
|--|----------------|---|----------|
| Full name of bank                      | Routing number | Account number  |          |
| Name of bank account owner or business |                | <input type="checkbox"/> Checking<br><input type="checkbox"/> Savings |          |
| Address of bank account owner          | City           | State   | ZIP code |
| Name of joint bank account owner       |                |   |          |
| Address, if different than above       | City           | State   | ZIP code |
| Email of account owner                 |                |   |          |

## General Authorization

I authorize Thrivent Financial for Lutherans ("Thrivent") to:

- make electronic deposits, withdrawals, and corrections to my bank account that comply with U.S. law;
- act on this authorization until I revoke it by contacting Thrivent;
- apply this authorization to any future bank accounts I may designate;
- make administrative changes to this authorization which I request such as date and amount changes, or adding or removing contracts for automatic payment;
- release any and all information related to this authorization to the third party account/contract owner;
- act upon electronic deposit, credit, and administrative instructions I provide to my Thrivent representative.

|                            |             |
|----------------------------|-------------|
| Signature of account owner | Date signed |
| <b>X</b>                   |             |

## Provider Service Report Instruction Page

A representative from each health care facility, agency, or independent care provider from which care was received must complete a Provider Service Report. Make additional copies for this purpose as needed. Any cost for completion of this form is the responsibility of the claimant.

### Instructions:

1. Complete the entire Provider Service Report.

2. **Attach a copy of any or all of the items below, if available.**

**Check each item sent.**

- ☐ Your facility license(s) or additional certifications for the area of the facility where the claimant resides or for the services you provide, if a license is required by state or federal regulations.
  - ☐ License not required by state or federal regulation
  - ☐ No license available
- ☐ Admission Assessment
- ☐ Cognitive Test Results, including date of test, (such as Mini Mental State Examination (MMSE), St Louis University Mental Status (SLUMS), or Montreal Cognitive Assessment (MOCA))
- ☐ Plan of Care/Care Plan/Individual Service Plan, prepared and signed by a Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)
- ☐ Hospital Discharge Summary, if applicable
- ☐ Initial Billing statements from each qualifying care provider. Additional bills may be needed.

3. Return the completed form(s) and supporting documents to: **Long-Term Care Claims**

**Thrivent**  
**PO Box 8075**  
**Appleton, WI 54912-8075**  
or fax to **800-225-2264**.

**Provider Service Report**  
**Nursing Facility, Home Health**  
**Care Agency, Other**

|             |
|-------------|
| Thrivent ID |
|-------------|

|                 |
|-----------------|
| Contract number |
|-----------------|

Name of claimant (Print first, middle, last name and suffix, as applicable)

|                           |   |
|---------------------------|---|
| Name of facility/provider | Provider relationship to claimant, if any |
|---------------------------|---|

|                              |      |       |          |
|------------------------------|------|-------|----------|
| Address of facility/provider | City | State | ZIP code |
|------------------------------|------|-------|----------|

|                            |                                 |
|----------------------------|---------------------------------|
| Phone of facility/provider | Fax number of facility/provider |
|----------------------------|---------------------------------|

**Certification - Must be signed by a Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)**

**I certify that the above named patient (check at least one box):**

- ☐ Is unable to perform without hands-on or standby assistance from another individual, \_\_\_\_\_ Activities of Daily Living (ADLs) due to loss of functional capacity and this condition is expected to last for at least 90 days; **OR** due to a cognitive impairment, requires supervision to protect her/him self or others from threats to health or safety, which may include cueing by verbal prompting, gestures, or other demonstrations.
- ☐ Does not need assistance for at least 90 days to perform the activities of daily living and does not require supervision due to a cognitive impairment.

**As signer, I certify that I am (check one box):**

- ☐ A physician licensed in the United States within the meaning of Section 1861(r)(1) of the Social Security Act who is a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which I perform such function or action.
- ☐ A registered professional nurse (i.e., Registered Nurse (R.N.), B.S.N., M.S.N., or Nurse Practitioner).
- ☐ A licensed social worker (L.S.W.) who has the requisite educational degree(s) and who is qualified by training to assess physical and cognitive impairment.
- ☐ No registered professional nurse (i.e., Registered Nurse (R.N.), B.S.N., M.S.N., or Nurse Practitioner) or licensed social worker (L.S.W.) on staff.

Printed Name of Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)

|   |             |
|---|-------------|
| Signature of Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.) | Date signed |
|---|-------------|

**X**

Services provided by facility/provider to this claimant: ☐ Nursing home ☐ Assisted living ☐ Home care  
☐ Independent living ☐ Respite care ☐ Other (specify) - \_\_\_\_\_

On what date did your services begin? \_\_\_\_\_

☐ Yes ☐ No Is the claimant still at your facility?

If the claimant has been discharged from your care, indicate last date of service - \_\_\_\_\_

☐ Yes ☐ No Was there a change of condition after admission to your facility?

If yes, what date did the change occur? \_\_\_\_\_

☐ Yes ☐ No Is Medicare covering/has Medicare covered any of the claimant's stay/services? **If yes**, dates are required.

## Provider Service Report - Nursing Facility, Home Health Care Agency (continued)

Claimant's diagnosis and impairment:

☐ Yes ☐ No Does the claimant need help or supervision because of a deficiency in the ability to think, perceive, reason and remember? **If yes**, explain the services you or your facility provides, relating to the cognitive impairment. NOTE: Medication management is not a benefit eligibility trigger.

Indicate the level of assistance you are **providing** with the following Activities of Daily Living (check all that apply). Occasional assistance should be noted.

### Bathing:

- ☐ Independent  
☐ Total assistance  
☐ Standby/hands-on assistance  
☐ Cueing/reminders only  
Frequency of assistance - \_\_\_\_\_

### Transferring:

- ☐ Independent  
☐ Total assistance  
☐ Standby/hands-on assistance  
☐ Cueing/reminders only  
Frequency of assistance - \_\_\_\_\_

### Continence:

- ☐ Continent  
☐ Incontinent, self-managed  
☐ Incontinent, staff assistance with pericare  
☐ Cueing/reminders only  
Frequency of assistance - \_\_\_\_\_

### Ambulation/Walking Indoors:

- ☐ Independent - with or without cane/walker/wheelchair  
☐ Bed bound  
☐ Wheelchair dependent and assistance provided  
☐ Standby/hands-on assistance  
☐ Cueing/reminders only  
Frequency of assistance - \_\_\_\_\_

### Eating (does not include preparing meals):

- ☐ Independent  
☐ Aspirates (choking danger when fed)  
☐ Is spoon fed  
☐ Assistance getting food to mouth  
☐ Cueing/reminders only  
Frequency of assistance - \_\_\_\_\_

### Dressing:

- ☐ Independent  
☐ Fastening buttons/zippers  
☐ Putting on/taking off clothes  
☐ Selecting clothing/getting from closet or dresser  
☐ Application of Ted Hose  
☐ Cueing/reminders only  
Frequency of assistance - \_\_\_\_\_

### Using the Toilet:

- ☐ Independent  
☐ Assistance performing pericare  
☐ Total assistance  
☐ Assistance getting on/off toilet  
☐ Assistance getting to/from toilet  
☐ Cueing/reminders only  
Frequency of assistance - \_\_\_\_\_

Additional comments

**For your protection**, state laws require the following to appear on this form: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files or facilitates the filing of a statement of claim containing any materially false information, or conceals information concerning any fact material to the statement, may be guilty of insurance fraud, which may be a felony crime, subject to civil penalties or criminal prosecution, including substantial fines and/or confinement in prison.

Authorized signature of provider (facility, home health agency, other)

Date Signed

**X**  
Title

## Attending Physician Statement/Plan of Care

Thrivent ID

Contract number

**Any cost for completion of this form is the responsibility of the patient.**

Name of patient

Date of birth

Date you last assessed this patient

*If you have not assessed this patient within the last six months, please conduct an evaluation before completing this form.*

**Certification - Must be signed by a Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)**

**I certify that the above named patient (check at least one box):**

- ☐ Is unable to perform without hands-on or standby assistance from another individual, \_\_\_\_\_ Activities of Daily Living (ADLs) due to loss of functional capacity and this condition is expected to last for at least 90 days; **OR** due to a cognitive impairment, requires supervision to protect her/him self or others from threats to health or safety, which may include cueing by verbal prompting, gestures, or other demonstrations.
- ☐ Does not need assistance for at least 90 days to perform the activities of daily living and does not require supervision due to a cognitive impairment.

**As signer, I certify that I am (check one box):**

- ☐ A physician licensed in the United States within the meaning of Section 1861(r)(1) of the Social Security Act who is a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which I perform such function or action.
- ☐ A registered professional nurse (i.e., Registered Nurse (R.N.), B.S.N., M.S.N., or Nurse Practitioner).
- ☐ A licensed social worker (L.S.W.) who has the requisite educational degree(s) and who is qualified by training to assess physical and cognitive impairment.

Printed Name of Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)

Degree

Address

City

State

ZIP code

Phone

Fax number

Signature of Doctor (M.D. or D.O.), Registered Nurse (R.N.), or Licensed Social Worker (L.S.W.)

Date signed

**X**

**For your protection**, state laws require the following to appear on this form: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files or facilitates the filing of a statement of claim containing any materially false information, or conceals information concerning any fact material to the statement, may be guilty of insurance fraud, which may be a felony crime, subject to civil penalties or criminal prosecution, including substantial fines and/or confinement in prison.

## Attending Physician Statement/Plan of Care (continued)

Primary medical diagnosis and ICD code(s):

Provide list of cognitive test scores, if available:

☐ Yes ☐ No Does the patient need help or supervision because of a deficiency in the ability to think, perceive, reason and remember?

### Plan of Care

| Type of Care Recommended<br>(Assisted living, nursing home,<br>home health care, etc) | Reason for Care<br>(Describe claimant's physical<br>or cognitive impairment) | Frequency per<br>Week and Hours<br>per day<br>(Daily, weekly,<br>bi-weekly, etc.) | Duration of<br>Care<br>(How long is the<br>care expected<br>to last?) |
|---|--|---|---|
|   |  |   |   |
|   |  |   |   |
|   |  |   |   |

Please indicate if the claimant is getting hands on or standby assistance with ANY of the following:

#### Bathing:

- ☐ Yes Level of assistance \_\_\_\_\_  
☐ No  
☐ Cueing/reminders only

#### Continence:

- ☐ Incontinent Level of assistance \_\_\_\_\_  
☐ Continent

#### Transferring:

- ☐ Yes Level of assistance \_\_\_\_\_  
☐ No  
☐ Cueing/reminders only

#### Using the Toilet:

- ☐ Yes Level of assistance \_\_\_\_\_  
☐ No  
☐ Cueing/reminders only

#### Eating (does not include preparing meals):

- ☐ Yes Level of assistance \_\_\_\_\_  
☐ No  
☐ Cueing/reminders only

#### Dressing:

- ☐ Yes Level of assistance \_\_\_\_\_  
☐ No  
☐ Cueing/reminders only

#### Ambulation/Walking Indoors:

- ☐ Yes Level of assistance \_\_\_\_\_  
☐ No  
☐ Cueing/reminders only

Additional comments

Return the completed form(s) and supporting documents to: **Long-Term Care Claims**  
**Thrivent**  
**PO Box 8075**  
**Appleton, WI 54912-8075**  
or fax to **800-225-2264**.