BANKERS LIFE AND CASUALTY COMPANY
We specialize in seniors

Telephone: 1-800-621-3724
PO Box 66994
Chicago, IL 60666-0994

WHEN YOU NEED BENEFITS UNDER YOUR LONG TERM CARE / FACILITY / HOME HEALTH CARE COVERAGE

CLAIMS SPECIALSTS

We want to help you best utilize the benefits under your policy. You or your family can call our Claims Specialist at 1-800-621-3724.

On the back of this form, we have listed information that would be helpful for you to have available when you call. The Claims Specialist will ask you some questions and, when appropriate, refer your case to a Patient Care Coordinator. The Patient Care Coordinator's function is to assist you in identifying qualified providers and guide you in the process of initiating your physician's plan of care.

CLAIM FORM

When you have already incurred a claim, we need the 15626 claim form completed. You can visit our website www.bankerslife.com to print the form, or contact your agent or local office for the 15626 claim form.

Please remember to review your policy before submitting your claim to determine if you need to have Form D or Form E completed. We do not need both D and E. We only need the form that applies to the type of care you are receiving.

1. Be sure you and your doctor answer ALL of the questions on forms A, B and C.
2. Use Form D for facility care. Give the form to the Facility to be completed in full.
3. Use Form E for Home Health Care, Respite, Hospice or Adult Day Care. Give the form to the provider to be completed in full.
4. Forms D and E require that the facility or provider attach other documents supporting your application for benefits. These are shown in **bold** on the forms.
5. Attach the bills (we don't pay advance billings) and mail to Bankers Life and Casualty Company, PO Box 66994, Chicago, IL 60666-0994.

QUESTIONS

If you have any questions about your coverage or how to file a claim, please call 1-800-621-3724 or visit our website at www.bankerslife.com.

CLAIMS SPECIALIST / PATIENT CARE COORDINATOR CHECKLIST

THE FOLLOWING INFORMATION ***MAY*** BE ASKED OF YOU WHEN YOU CALL A BANKERS CLAIMS SPECIALIST. PLEASE HAVE THE FOLLOWING INFORMATION READY WHEN YOU CALL:

☐ **POLICY NUMBERS**

____________________ , ____________________ , ____________________

☐ **PATIENT INFORMATION**

a. Name: ____________________

b. Social Security Number: ____________________

c. Address: ____________________

____

d. Patient phone: ____________________

e. Contact person (if other than insured):____________________

f. Contact person's phone: ____________________

☐ **ATTENDING DOCTOR**

a. Name: ____________________

b. Phone: ____________________

☐ **TYPE OF CARE NEEDED** (THAT IS, FACILITY, LONG TERM CARE, HOME HEALTH, OTHER)

____

☐ **NAME OF AGENCY OR FACILITY WHO WILL PROVIDE THE CARE (IF KNOWN) OR AGENCY/SOCIAL WORKER ASSIGNED TO HELP WITH PLANNING THE PATIENT'S TREATMENT**

a. Name: ____________________

b. Address: ____________________

c. Phone: ____________________

Bankers Life and Casualty Company
P.O. Box 66994
Chicago, IL 60666-0994
800-621-3724

For accurate and prompt servicing of your claim, please have the following forms completed and mail them to:

Bankers Life and Casualty Company
Policy Benefits Department
P.O. Box 66994
Chicago, IL 60666-0994

Form A **APPLICATION FOR BENEFITS** – must be completed in full by you or your representative.

Form B **AUTHORIZATION** – must be completed in full by you or your representative.

Form C **LICENSED HEALTH CARE PRACTITIONER'S FORM** – must be completed in full by your practitioner (usually this is your doctor).

Form D **FACILITY FORM** - must be completed by the facility if you are claiming facility benefits (nursing home, assisted living).

Form E **HOME HEALTH, RESPITE, HOSPICE, ADULT DAY CARE FORM** – must be completed by your provider/agency if you are claiming these benefits.

Forms D and E require that the facility or provider attach other documents supporting the application for benefits. These are highlighted on the claim forms.

All claims are subject to receipt of proper proof of loss and are subject to all the provisions, definitions, limitations and exceptions of your insurance policy.

If you have questions or need assistance on how to file a claim, please contact your Agent, or call us at 1-800-621-3724. You can also visit us at our web site at www.bankers.com

We specialize in seniors

Form A. Application for Long Term Care Benefits

BANKERS LIFE AND CASUALTY COMPANY
P.O. Box 66994
Chicago, IL 60666-0994
800-621-3724

1. PATIENT'S NAME

POLICY NUMBERS

ADDRESS *(IF ADDRESS IS NEW, CHECK BOX ☐)*

SOCIAL SECURITY NUMBER

_________ – _________ – _______________

PHONE NUMBER

(   )

DATE OF BIRTH

MO____DAY____YR________

2. PRIMARY CARE PHYSICIAN'S NAME:

ADDRESS

PHONE NUMBER

(   )

3. HAVE YOU APPLIED FOR OR ARE YOU RECEIVING BENEFITS FROM:

(A) OTHER LONG TERM CARE COVERAGE? ☐ YES ☐ NO

If Yes, company name:

(B) MEDICARE? ☐ YES ☐ NO

(C) OTHER? ☐ YES ☐ NO *(If Yes, Please Specify)*

Form A. Application for Long Term Care Benefits

BANKERS LIFE AND CASUALTY COMPANY
P.O. Box 66994
Chicago, IL 60666-0994
800-621-3724

POLICY NUMBERS:

4. PLEASE INDICATE WHICH OF THE FOLLOWING YOU ARE APPLYING FOR:

☐ **A. FACILITY CARE** **ADMIT DATE:** MO____DAY____YR________

- ☐ NURSING HOME
- ☐ ASSISTED LIVING
- ☐ OTHER, SPECIFY: ________________________________

NAME OF FACILITY

ADDRESS

PHONE	CONTACT PERSON
( )	

☐ **B. HOME HEALTH OR COMMUNITY BASED SERVICES** **FIRST SERVICE DATE:** MO____DAY____YR________

- ☐ HOME HEALTH
- ☐ HOSPICE
- ☐ ADULT DAY CARE
- ☐ HOMEMAKER
- ☐ OTHER, SPECIFY: ________________________________

NAME OF PROVIDER/AGENCY

ADDRESS

PHONE

(   )

☐ **C. OTHER**

- ☐ EMERGENCY MEDICAL RESPONSE SYSTEM
- ☐ CARE GIVER TRAINING
- ☐ RESPITE
- ☐ HOME MODIFICATION:

DESCRIBE: ________________________________

Form B. Authorization

Bankers Life and Casualty Company
P.O. Box 66994
Chicago, IL 60666-0994
800-621-3724

POLICY NUMBERS:

I hereby authorize any medical professional, hospital, or other medical-care institution, insurance support organization, governmental agency, insurance company, employer, or other organization, institution or person that has any information, records or knowledge of me or my health to furnish to Bankers Life and Casualty Company or its representatives and permit them to examine and copy any information. I understand that such information will be used for the purpose of evaluating my claim for insurance benefits and that I acknowledge that I or my authorized representative have a right to a copy of this authorization upon request. A copy of this authorization, or the original shall be valid from the date signed for the duration of the claim or the term of the coverage.

YOUR STATE REQUIRES US TO NOTIFY YOU THAT: Any person who knowingly and with the intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony as further defined by your state statute.

IMPORTANT – Patient please sign here:

X ____ DATE: MO____DAY____YR________
(SIGNATURE OF PATIENT/RESPONSIBLE PARTY)

IF POWER OF ATTORNEY OR GUARDIAN, PLEASE ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION.

POWER OF ATTORNEY/GUARDIAN'S NAME:____

ADDRESS: ____

____

PHONE NUMBER: (______)____

Form C. Licensed Health Care Practitioner's Claim Form

BANKERS LIFE AND CASUALTY COMPANY
P.O. Box 66994
Chicago, IL 60666-0994
800-621-3724

Please provide the information requested below regarding the following person:

PATIENT'S NAME	**POLICY NUMBERS**

A. DIAGNOSIS AND BACKGROUND

Primary diagnosis related to the need for care:

Date Diagnosed

MO____DAY____YR________

Other pertinent diagnoses:

______________________________ Date Diagnosed: MO____DAY____YR________

______________________________ Date Diagnosed: MO____DAY____YR________

______________________________ Date Diagnosed: MO____DAY____YR________

Was the patient referred to you by another physician? ☐ YES ☐ NO

If Yes, please provide the name and address of the referring physician:

____

____

____

B. PATIENT'S FUNCTIONAL CAPACITY

For each ADL, check the box that best describes patient's current level of ability in that ADL.

	No Assistance needed. Independent.	Requires equipment to perform ADL. Please specify.	Requires supervisory or stand-by assistance of another person.	Requires hands-on assist of another person.
Bathing				
Continence				
Dressing				
Eating				
Toileting				
Transferring				
Other, Please Specify				

Form C. Licensed Health Care Practitioner's Claim Form

BANKERS LIFE AND CASUALTY COMPANY
P.O. Box 66994
Chicago, IL 60666-0994
800-621-3724

POLICY NUMBERS:

B. PATIENT'S FUNCTIONAL CAPACITY (CONTINUED)

Use the space below to provide additional information on this patient's ability to perform the ADLs:

If the patient requires on-going Stand-by or Hands-on Assistance in the ADLs listed, do you expect that this loss of functional capacity will last for at least 90 days from the date of the onset of the loss? ☐ YES ☐ NO

If Yes, indicate dates and explain below:

FROM: MO____DAY____YR_______ TO: MO____DAY____YR_______

C. PATIENT'S COGNITIVE CAPACITY INFORMATION

Has the patient experienced a deterioration or loss of intellectual capacity, which requires substantial supervision to protect the patient from threats to health or safety as measured by clinical evidence and standardized tests which reliably measure impairment in the following areas: (a) short term or long term memory, (b) orientation as to people, place and time and (c) deductive and abstract reasoning, or (d) judgment as it relates to safety awareness?

☐ YES ☐ NO

If Yes, answer questions (1), (2), and (3) below:

(1) Please describe clinical evidence or attach copies of appropriate medical records:

(2) Please identify standardized cognitive tests used and attach results:

(3) Does the deterioration or loss have an organic origin? ☐ YES ☐ NO

If No, explain:

Form C. Licensed Health Care Practitioner's Claim Form

BANKERS LIFE AND CASUALTY COMPANY
P.O. Box 66994
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POLICY NUMBERS:

D. PATIENT'S PLAN OF CARE

Is the patient receiving care under a written individualized program of care developed, supervised, and approved by you?

☐ YES ☐ NO

If Yes, then describe the program below (or attach description).

In the space provided below, please document the Plan of Care for each service required by this patient. Include all service providers, required durable medical equipment, and prescription drugs and supplies.

The following Plan of Care is valid for the following dates:

FROM: MO____DAY____YR_______ TO: MO____DAY____YR_______

NOTE: THE PLAN OF CARE WILL NOT BE VALID FOR MORE THAN 12 MONTHS.

Service Provider (e.g. RN, CNA, Nursing Home, ALF, informal care, etc)	Service Provided (e.g., skilled care, help with ADLs, supervision, etc)	Provider's Name or Agency/ Facility Name/ Phone No.	Frequency per Week and Hours per Day	Projected Duration	Start Date of Service
A.					
B.					
C.					
D. For Hospice Care					Date of Certification: MO __________ DAY__________ YR __________

Practitioner's Signature: ______________________________Date: MO____DAY____YR________

Practitioner's Name: ____

Phone No.: (   )______________________________Fax Number: (   )____________________

Address: ____

City: ____________________ State:______________TIN Number:____________________

15626-FN (8/06)

Form D. Long Term Care Facility Claim Form*

Bankers Life and Casualty Company
P.O. Box 66994
Chicago, IL 60666-0994
800-621-3724

1. PATIENT'S NAME

POLICY NUMBERS

2. ADMIT DATE

DISCHARGE DATE

MO____DAY____YR________

3. INDICATE EACH LEVEL OF CARE RECEIVED, DATES, AND ATTACH CORRESPONDING LICENSE(S):

___ SKILLED FROM: MO____DAY____YR________ TO: MO____DAY____YR________

___ INTERMEDIATE FROM: MO____DAY____YR________ TO: MO____DAY____YR________

___ CUSTODIAL FROM: MO____DAY____YR________ TO: MO____DAY____YR________

___ ASSISTED LIVING FROM: MO____DAY____YR________ TO: MO____DAY____YR________

___ INDEPENDENT LIVING FROM: MO____DAY____YR________ TO: MO____DAY____YR________

___ OTHER ________________ FROM: MO____DAY____YR________ TO: MO____DAY____YR________

4. LIST ABSENCES:

DATES: FROM: MO____DAY____YR________ TO: MO____DAY____YR________

REASON: ____

DATES: FROM: MO____DAY____YR________ TO: MO____DAY____YR________

REASON: ____

5. WAS ANY PORTION OF THIS CONFINEMENT COVERED BY MEDICARE?

☐ YES ☐ NO

If Yes, list dates and attach billing or EOMB (Explanation of Medicare Benefits):

FROM: MO____DAY____YR________ TO: MO____DAY____YR________

*PLEASE REVIEW YOUR POLICY TO ENSURE THESE BENEFITS ARE COVERED.

Form D. Long Term Care Facility Claim Form*

BANKERS LIFE AND CASUALTY COMPANY
P.O. Box 66994
Chicago, IL 60666-0994
800-621-3724

POLICY NUMBERS:

6. IS THIS PATIENT A MEDICAID RECIPIENT? ☐ YES ☐ NO

If Yes, list eligibility date: MO____DAY____YR________

7. WAS PATIENT CONFINED TO ANOTHER FACILITY OR HOSPITAL PRIOR TO THIS ADMISSION? ☐ YES ☐ NO

If Yes, give name and address of facility and dates of confinement.

FACILITY: ____________________

DATES: FROM: MO____DAY____YR________ TO: MO____DAY____YR________

FACILITY: ____________________

DATES: FROM: MO____DAY____YR________ TO: MO____DAY____YR________

A COPY OF THE ITEMIZED BILL, ALL ASSESSMENTS, RESIDENT AGREEMENTS, FEE SCHEDULES, ALL PLANS OF CARE/SERVICE PLANS, ANY BENEFIT ASSIGNMENTS, AND APPROPRIATE LICENSES MUST ACCOMPANY THIS FORM.

NAME OF FACILITY: ____________________

TAX ID NUMBER: ____________________

ADDRESS: ____________________

____

SIGNATURE: ____________________ DATE: MO____DAY____YR________

PRINTED NAME: ____________________

TITLE: ____________________

TELEPHONE NO. AND EXT. (   ) ____________________ FAX NO. (   ) ____________________

*PLEASE REVIEW YOUR POLICY TO ENSURE THESE BENEFITS ARE COVERED.

Form E. Home Health / Respite / Hospice / Adult Day Care & Other Provider Claim Form*

BANKERS LIFE AND CASUALTY COMPANY
P.O. Box 66994
Chicago, IL 60666-0994
800-621-3724

1. PATIENT NAME

2. POLICY NUMBERS

3. AGENCY/PROVIDER NAME

4. TAX ID NUMBER

5. AGENCY/PROVIDER ADDRESS

____

____

6. AGENCY/PROVIDER PHONE NUMBER

( ) ______________________________

7. AGENCY/PROVIDER FAX NUMBER

( ) ______________________________

8. INDICATE THE TYPE OF CARE AND DATES:

___ HOME HEALTH FROM: MO____DAY____YR________ TO: MO____DAY____YR________

___ HOSPICE FROM: MO____DAY____YR________ TO: MO____DAY____YR________

___ ADULT DAY CARE FROM: MO____DAY____YR________ TO: MO____DAY____YR________

___ HOMEMAKER FROM: MO____DAY____YR________ TO: MO____DAY____YR________

___ CARE GIVER TRAINING FROM: MO____DAY____YR________ TO: MO____DAY____YR________

NAME OF PERSON BEING TRAINED: ______________________________

RELATIONSHIP TO PATIENT:______________________________

___ OTHER, SPECIFY FROM: MO____DAY____YR________ TO: MO____DAY____YR________

*PLEASE REVIEW YOUR POLICY TO ENSURE THESE BENEFITS ARE COVERED.

Form E. Home Health / Respite / Hospice / Adult Day Care & Other Provider Claim Form*

BANKERS LIFE AND CASUALTY COMPANY
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800-621-3724

POLICY NUMBERS:

9.TYPE OF LICENSE(S) HELD BY THE AGENCY/PROVIDER:

____

____

DATE LICENSE(S) EXPIRES: MO____DAY____YR________

PLEASE ATTACH A COPY OF THE LICENSE(S).

10. ARE YOU MEDICARE CERTIFIED? ☐ YES ☐ NO

If Yes, was this claim filed with Medicare? ☐ YES ☐ NO

DATES MEDICARE APPROVED: FROM: MO____DAY____YR________ TO: MO____DAY____YR________

DATES MEDICARE DENIED: FROM: MO____DAY____YR________ TO: MO____DAY____YR________

DENIAL REASONS:

____

____

____

PLEASE ATTACH ITEMIZED BILLS, COPY OF THE PHYSICIAN'S PLAN OF TREATMENT/ CERTIFICATION, DAILY CARE NOTES, ANY BENEFIT ASSIGNMENTS, AND COPIES OF ANY LICENSES.

COMPLETED BY: ____

SIGNATURE: ________________________________ DATE: MO____DAY____YR________

PRINTED NAME: ____

TITLE: ____

*PLEASE REVIEW YOUR POLICY TO ENSURE THESE BENEFITS ARE COVERED.