Long-Term Care Claim Appeal Request

Before filing an appeal, we encourage you to contact the Long-Term Care Customer Service Department at the number below to discuss the details of your claim denial. If a Customer Service Representative cannot resolve your inquiry over the phone, you will be prompted to proceed with the formal appeal process using this form as a guide.

How to File an Appeal

Step 1: Provide the following information

Insured Name: ___________________________ Date of Birth: ___________________________

Policy Number(s): ______________________ Current State of Residence: ______________________

Care Provider(s): ______________________

Date(s) of Service in Question: ______________________

Step 2: Select the option that best describes your appeal request

☐ You disagree with our decision and request that we reconsider the claim with the information you already submitted.

☐ You disagree with our decision and have additional information for us to consider. Check the following boxes to describe what you are sending with this form.

☐ Cognitive testing ☐ Medical records ☐ Service plans
☐ Daily home health care visit notes ☐ Healthcare provider assessments
☐ Other: __________________________________________________________

*If you would like us to request the above information from a physician or provider, include below any necessary contact information and make sure to enclose a completed Claims Authorization for Medical Information form, which is included for your convenience.

Physician/Provider Name: ___________________________ Telephone Number: ___________________________

Address: ________________________________________________________________________________

Step 3: Summarize the reason for your appeal on a separate piece of paper (not the back of this form).

Step 4: Submit forms and supporting documents in one of the following ways:

• Upload at: https://www.bankerslife.com/service-support/document-upload/

• Mail to the address listed below

• Fax to the number listed below

We will acknowledge your request within two weeks of receipt. Please allow 30 days for our review. Our final decision will be sent in writing to the insured’s address of record.

Signature: ___________________________ Relationship to the Insured: ___________________________

Phone: ___________________________ Date: ___________________________

Questions regarding this form or the appeal process? Please contact our Customer Service Department at the number below between the hours of 8:00 AM and 6:00 PM Central Time.
This is a medical release of information form. This form is used to allow your medical information to be released to Bankers Life and Casualty Company for the purpose of reviewing your claim for benefits.

1. **My Information – the individual whose medical information is to be released**

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Date of Birth</th>
<th>Soc. Sec. Number (last 4 digits)</th>
<th>Policy Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

2. **Disclosing Party – the party or parties authorized to release information about me**

   Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration or governmental agency.

3. **Description of my information authorized for release**

   Any/all information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse.

4. **Purpose of Authorization – how my information will be used**

   To administer benefits under a policy or certificate of insurance.

5. **Duration or Authorization**

   Twenty-four (24) months from the date written below, unless I specify an earlier date here: ______

6. **Receiving Parties – the parties authorized to receive information about me**

   Bankers Life and Casualty Company, its agents, representatives and reinsurers

7. **Important information – review carefully before signing**

   - Refusing to sign this Authorization does not affect my ability to obtain medical treatment, but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage.
   - This Authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: LTC Claims Administration P.O. Box 1902, Carmel, IN 46082-1902.
   - The Receiving parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected.
   - I understand that I (or my authorized representative) have a right to a copy of this Authorization, and that a photocopy or facsimile is as valid as the original.
   - Obtain a large print version of this form by calling 800-621-3724 and requesting form 18727-LARGE

8. **Approval – must be signed and dated by me or my Legal Representative* to be valid**

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Relationship to the insured</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date Signed</th>
</tr>
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*Legal Representative must provide documentation of legal authority