ALASKACARE
Retiree Health Plan

Phone: 888-287-7116
Fax: 866-383-4498

P.O. Box 13431
Pensacola, FL 32591

Date

Name
Address
City, State, Zip

Re: Policy #

Dear (Insured):

Thank you for contacting us in regard to accessing Home Health Care Benefits under your Long Term Care policy. Please find below the instructions for filing a claim and the enclosed claim forms to be completed by you, your primary care physician and care provider.

INSTRUCTIONS FOR FILING A CLAIM

- Insured or insured's legal representative (Power of Attorney) fully complete, sign and date:
  - Insured Claim Form; Fraud Notice; and Authorization to Obtain and Release Medical Information; and
  - Provide a copy of Power of Attorney document (if applicable)

- Primary Care Physician fully complete, sign and date:
  - Attending Physician's Statement; and Fraud Notice

In addition to the requested claim form we may request copies of your medical records or a nurse may contact you to schedule a face-to-face assessment.

- Home Health Care Agency representative fully complete, sign and date:
  - Home Health Care Agency Statement and Fraud Notice; and
  - Provide a copy of Agency License and W-9 Form
  - Provide copies of Service Invoices and Daily Care Logs for all dates of services
  - Provide a copy of the Home Health Care Agency's Fee Schedule.

Please return the completed claim forms and documents by facsimile to 866-383-4498 or by mail to the address as stated in the letterhead above. Upon receipt of the completed claim forms, other requested documents and copies of your medical records we will review your claim for benefit consideration. If we find additional information is needed to complete our review we will notify you accordingly.

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Pensacola, FL 32591

Your cooperation and assistance in the handling of your claim is appreciated. If you have any questions concerning the handling of your claim, the requested documentation or completion of the enclosed claim forms please call our Customer Service department at (888) 287-7116.

Sincerely,

Claims Department

Insured Claim Form

Complete this form and return to: SOA Claims, P.O. Box 13431, Pensacola FL 32591
(*An authorized representative may complete this form if the insured is unable to do so)*

DEMOGRAPHICS

Insured Name				DOB	
Gender			Phone		
Insured's Current Address					
Is There a POA, Guardian or healthcare proxy?		POA, Guardian or healthcare proxy's Name			
POA/Guardian Phone					
POA/Guardian Address					
Insured's Marital Status		Live Alone?		With whom?	
Height				Weight	
Driver's License?				Still drive?	
Currently Employed:				Occupation:	

MEDICAL

Primary Care Physician:				1st visit Last Visit	
PCP address:			Phone		
Other Physician				1st visit Last Visit	
Specialty					
Other Physician Address			Phone		
Other Physician				1st visit Last Visit	
Specialty					
Other Physician Address			Phone		
Other Physician				1st visit Last Visit	
Specialty					
Other Physician Address			Phone		
Recent Hospitalization				Admit Discharge	
Hospital Address					
Reason for Hospitalization					
Diagnosis 1:		Diagnosis 2:			
Diagnosis 3:		Diagnosis 4:			

LIST MEDICATIONS

Medication	Dose	Frequency	When Prescribed	Why taken ?

MEDICAL EQUIPMENT

Type and start of use

ACTIVITES OF DAILY LIVING:

Does the insured have assistance with any of the following?

Bathing		If yes, how often		When Started?	
Dressing		If yes, how often		When Started?	
Transferring		If yes, how often		When Started?	
Eating		If yes, how often		When Started?	
Toileting		If yes, how often		When Started?	
Continence		If yes, how often		When Started?	

INSTRUMENTAL ACTIVITES OF DAILY LIVING:

Does the insured have assistance with any of the following?

Shopping		When Started?	
Housekeeping		When Started?	
Cooking		When Started?	
Transportation		When Started?	
Laundry		When Started?	
Indoor mobility		When Started?	
Outdoor mobility		When Started?	

COGNITIVE STATUS

Does the insured have any memory problems?

Does the insured have cognitive issues?		When Started?	
Does the insured wander?		When Started?	
Is the insured physically or verbally abusive?		When Started?	
Does the insured have poor hygiene?		When Started?	
Does the insured make poor judgments?		When Started?	
Is the insured uncooperative with care?		When Started?	
Can he or she be left alone?		When Started?	

CURRENT SERVICES

Formal Provider		When Started?	
Provider Address			
Provider Phone #		Contact	
Formal Provider		When Started?	
Provider Address			
Provider Phone #		Contact	
Informal Provider		When Started?	
Provider Address			
Provider Phone #		Contact	

Are current services satisfactory?

How long do you anticipate services will be needed?

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NEW HAMPSHIRE: Any person who, with a purpose to injure, defrauds 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.
NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
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TEXAS: Any person who knowingly presents a 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.

I have read and understood the above

Signed: _____ Date: _____

Insured or Legal Representative

Authorization to Obtain and Release Medical Information
This authorization is intended to comply with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

Complete this form and return to:
(*An authorized representative may complete this form if the insured is unable to do so)*

Alaska Care Claims
P.O. Box 13431 Pensacola FL 32591
Phone:888-287-7116
Fax: 866-383-4498

Insured Name: _____ Date of Birth: _____

I hereby authorize the following uses and disclosures of health information about me.

1. The health information that I am authorizing to be used or disclosed consists of all of the following information:
My medical records and medical history; and other information that relates to:
- The diagnosis of any physical or mental condition,
- The treatment of prognosis of any physical or mental condition,

whether such treatment is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions such as AIDS, or sexually transmitted diseases.

2. The following persons or entities are authorized to disclose health information about me: A doctor; medical practitioner; hospital; clinic or medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including Kanawha Insurance Company); any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB) or any other organization, institution, or person having health information about me.

3. Health information about me may be disclosed to Kanawha Insurance Company and its affiliates, service providers, Kanawha Insurance Company's agents, and representatives, and to any consumer reporting agency such as the MIB.

4. Health information about me may be used or disclosed to evaluate or process any claim for long-term care insurance benefits or to service my long-term care insurance coverage. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory, and law enforcement entities.

5. Kanawha Insurance Company is authorized to disclose health information about me to the individuals designated below. (You should consider listing your spouse, partner, children, and/or any other family member or friend with whom you may want Kanawha Insurance Company to discuss your claim.)

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

6. I understand that:
- If I do not sign this Authorization, Alaska Care may decline to pay any claim for long-term care insurance benefits.
- Although an authorization may generally be revoked by sending a written request to Alaska Care, there is no right to revoke this Authorization if my claim for benefits may be contested by Alaska Care or if Alaska Care has already relied and acted upon this Authorization.
- My health information may be re-disclosed and no longer protected by HIPAA if the person receiving my health information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as Alaska Care and health care providers. However, Alaska Care does require its agents and service providers to protect the confidentiality of health information.
- A copy of this Authorization is as valid as the original.
- I will receive a copy of this Authorization.
- This Authorization expires when coverage under my long-term care insurance policy terminates.

_____	_____	_____	_____
Insured Signature (or Power of Attorney)	Printed Name	Policy Number	Date

If this Authorization is signed by a Power of Attorney (POA) for the insured, a copy of the POA document must be included

ATTENDING PHYSICIAN'S STATEMENT

Patient Name _____ Date of Birth _____

ICD Diagnosis and Concurrent Conditions (If diagnosis code other than ICD used, give name.)

Activities of Daily Living — Please indicate areas of daily living with which the patient requires assistance.

Bathing — means washing, including a sponge bath, with or without extra equipment. ☐ Yes ☐ No Comment_____

Continence — Maintenance of reasonable bowel/bladder personal hygiene. ☐ Yes ☐ No Comment_____

Dressing — putting on and taking off clothing. ☐ Yes ☐ No Comment_____

Feeding — consuming prepared food with or without adaptive utensils. Does not include preparation and cooking of food. ☐ Yes ☐ No Comment_____

Toileting — means both getting on and off the toilet and maintaining a reasonable level of personal hygiene. ☐ Yes ☐ No Comment_____

Transferring — moving from a bed to a wheelchair or other type of convenience or furniture and returning to bed, as needed. ☐ Yes ☐ No Comment_____

Mental Status

Does the patient suffer from a cognitive impairment making him or her unable to think, perceive, reason or remember? ☐ Yes ☐ No Comment_____

Is the patient mentally competent to understand ordinary business transactions andto receive proceeds of insurance? ☐ Yes ☐ No Comment_____

Additional Comments — Please outline any conditions making long term care medically necessary if not covered above.

Will current loss of functional capacity leave patient unable to perform two or more ADL's for 90 days? ☐ Yes ☐ No Comment_____

Has patient had such a loss during the past 12 months? ☐ Yes ☐ No Comment_____

Patient Care Requirements

Nursing Home Confinement? ☐ Yes ☐ No Authorized Duration _____ To _____

Hospice Confinement? ☐ Yes ☐ No Authorized Duration _____ To _____

Adult Day Care? ☐ Yes ☐ No Authorized Duration _____ To _____

Home Health Care? ☐ Yes ☐ No Authorized Duration _____ To _____

Other (Specify)? _____ ☐ Yes ☐ No Authorized Duration _____ To _____

Physician _____ T.I.N. or S.S.N. _____ Telephone _____

Address _____

Physician Signature _____ Date _____

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Signed: _____ Date: _____

Attending Physician

HOME HEALTH CARE AGENCY STATEMENT

(to be completed if your policy provides these benefits and you are making a claim)

Days of Home Health Care provided _____ From _____ To _____ Days of Homemaker _____ From _____ To _____

Benefits Provided		Service Provided	
Care Provided	☐ Assistance with bathing, dressing, feeding, toileting or transferring		☐ Shopping
			☐ Housekeeping
	☐ Occupational, respiratory, physical and speech therapy		☐ Transportation
	☐ Nursing services requiring the services of a licensed nurse		☐ Laundry
	☐ Constant supervision because a physician has determined that the patient has a cognitive impairment requiring such supervision		☐ Cooking

Degree or Title of Person Providing Care_____

Agency _____ Telephone (_____) _____

Name Street Address City/State Zip

Tax I.D. _____ State License No._____ Federal Certification No. _____

Signature _____ Title _____ Date _____

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Signed: _____ Date: _____

Home Health Care Representative