



**SENIOR HEALTH INSURANCE COMPANY OF
PENNSYLVANIA**

P.O. Box 64913 • St. Paul, MN 55164
Telephone: 1-877-450-5824

RE: Policy Number: _____

If you choose to assign your long term care insurance benefits to a covered provider you must submit additional information in writing to SHIP. The provider must agree to this Direction to Pay and be willing to bill SHIP directly for care/services provided to you. The Direction to Pay form is provided as a convenience to our policyholders and their care providers to assign benefits to the care provider, but not the rights under the policy.

In order to direct benefits to your care provider, SHIP needs the following:

- Complete the enclosed “Direction to Pay” form.
- Obtain the consent of the provider to accept assignment and bill us directly.
- Return the “Direction to Pay” form to SHIP or fax it to us at 952-983-5256.

In addition, the covered provider must send us a completed W-9 form (required by the IRS).

The “Direction to Pay” will not be in effect until we receive the completed “Direction to Pay” form from you and the completed W-9 form from your covered provider. Please return via fax: at 952-983-5256 or mail to:

SHIP
P. O. Box 64913
St. Paul, MN 55164

Should you have any questions, please contact Customer Service at 877-450-5824, between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time) Monday through Friday or visit our website at www.SHIPLTC.org.

Sincerely,
SHIP Customer Service



Direction to Pay

Claimant Name: _____

Coverage ID Number: _____

This Direction to Pay revokes any previous assignments authorized by, _____ the Claimant or the guardian of the Claimant (legal documentation of guardianship or other representative capacity, if appropriate, is attached), hereby authorize direct payment to _____ of any Long-Term Care benefits otherwise payable to or on behalf of the Claimant for the service provider at a rate not to exceed the Provider's regular charges. It is understood that this Direction to Pay does not transfer any rights under the policy of insurance. It is agreed that payment to the Provider, pursuant to this Direction to Pay, by the plan administrator shall discharge Senior Health Insurance Company of Pennsylvania (SHIP) of any and all obligation under the plan to the extent of such payments. It is understood by the undersigned that he/she is financially responsible for any charges not covered by this Direction to Pay.

Service Provider Representative Signature

Claimant/Legal Representative Signature

Printed Name of Service Provider Representative

Printed Name of Claimant/Legal Representative

Date _____

π Financial Power of Attorney is attached if signed by a Legal Representative

Name of Service Provider _____

Address of Service Provider _____

City: _____ State _____ Zip Code _____

Provider's Federal Tax ID Number _____

A completed W-9 form verifying the provider's Federal Tax Identification number is required for Benefit Assignment.