Senior Health Insurance Company of Pennsylvania

CLAIM INFORMATION PACKAGE

At Senior Health Insurance Company of Pennsylvania, we understand that filing a new long-term care insurance claim can be confusing. To provide clarity in filing a new claim, this claim information package is designed to provide you with straightforward instructions on how to file a claim under your long-term care policy.

Claim Filing Instructions:

1. The contents of this claim information package include:

   - Claim Forms - Claim forms must be completed for each new claim but the forms do not need to be submitted on an ongoing basis. There three claim forms:
     - **Policyholder Claim Form**: completed by the policyholder or legal representative
     - **Authorization for Use of Health-Related Information Form**: completed by the policyholder or legal representative
     - **Authorization for Disclosure of Health-Related Information Form**: (optional) completed by the policyholder or legal representative if you want to authorize anyone other than the policyholder to speak with us about your claim.
   - Direction to Pay Cover Letter and Form – this form should only be completed if you wish to assign claim payments directly to your provider. Please note that in order for us to pay the provider directly, we will only accept our Direction to Pay form.
   - Caregiver Weekly Timesheet – this form only needs to be completed for home health care claims and must be completed on a weekly basis to document the services provided each day
   - Continued Monthly Residence Form – this form only needs to be completed for facility claims and must be completed thoroughly by facility staff each month, on or after the last day of the month, after the services have been provided.
   - Nursing Facility Checklist – this is designed to help you stay organized while submitting a new nursing facility claim. This checklist does not need to be returned.
   - Home Health Care Checklist – this is designed to help you stay organized while submitting a new home health care claim. This checklist does not need to be returned.

2. Complete the **Policyholder Claim Form**. Complete the **Authorization for Use of Health-Related Information Form**. Also complete the **Authorization for Disclosure of Health-Related Information Form,** if you want to authorize anyone other than the policyholder to speak with us about your claim. Please submit all of these forms to us together. PLEASE ALSO MAKE SURE THAT ITEMIZED INVOICES ARE SUBMITTED TO US.

3. Provide copies of supporting documents that are applicable to your situation (e.g., Power of Attorney documentation). Ensure that your long-term care claim submission is complete by reviewing the enclosed checklist specific to the claim you are filing (Home Health Care or Nursing Facility). Submit your claim by mailing or faxing the claim information to us at the address or fax number listed on the bottom of each claim form.

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

INITIAL CLAIM TIMELINE (in business days)

DAY 1

- Written notice of claim received

- Written notice of claim received

DAYS 2-6

- Company sends claim acknowledgement letter and reviews claim for complete information

- Company sends claim acknowledgement letter and reviews claim for complete information

COMPLETE CLAIM RECEIVED

COMPLETE CLAIM NOT RECEIVED

DAYS 7 - 10

- Complete claim is received and eligibility decision is rendered and communicated

- Complete claim is not received and company requests additional information

DAYS 11-15

- Benefit payments are processed and mailed

DAYS 11-35

- If requested claim documents are received, claim decision is rendered and communicated (as noted in Days 7-10 on timeline).
- If requested claim documents are not received, company requests additional claim information.

DAYS 36-45

- If requested claim documents are received, claim decision is rendered and communicated (as noted in Days 7-10 on timeline).
- If requested claim documents are not received, claim is closed and will be reopened when additional information is received.

Once claim is approved and all invoices are received and reviewed, benefit payments are processed within 10 business days and mailed via USPS standard delivery. Please allow an additional 3-5 days for mail delivery.

If requested information is not received by Day 45, claim is closed and will be reopened when additional information is received.

Important Information

Please note that documents mailed or faxed separately will result in multiple acknowledgement letters to you for each separate mailing.

Please be sure to provide the telephone number and name of the person you would like us to contact to obtain additional information, if needed, on the Policyholder's Claim Form.

Approved Claims

Following the eligibility decision, if both you and your provider meet the requirements of your policy, you will receive written notification from us. However, benefits will still not be provided until we receive itemized invoices from either the policyholder, caregiver or facility. The care manager handling your claim will also attempt to call you or your authorized designee. Please be sure to provide the telephone number and name of the person who should be notified following the benefit determination.

When submitting your claim, you must provide itemized invoices documenting monthly, daily or hourly rates charged for each service date. **No benefits will be provided until itemized invoices are received by us from either the policyholder, facility or the caregiver(s). We will not be obtaining invoices on your behalf.** For Home Health Care claims, you must also provide Caregiver Weekly Timesheets or daily progress notes documenting the services you received for each day of paid care. For facility claims, you must also provide the Continued Monthly Residence form completed thoroughly by facility staff each month, on or after the last day of the month, after the services have been provided. If you prefer benefit payments be made directly to your provider, you must complete the Direction to Pay form, which is included in this package. The standard timeframe for benefit payments is five to ten business days from the date the claim is approved (or the date we receive the itemized invoice.) You will receive an explanation of benefits letter for all claims paid.

Ineligible Claims

Following the eligibility review, if either you or your provider do not meet the requirements outlined in your policy, you will receive written notification. The care manager handling your claim will also attempt to call you or your authorized designee to explain the reason for the benefit determination and explain the process to appeal a claim determination.

Should you have any questions regarding your policy benefits, please contact our Customer Service team by calling 877-450-5824, Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern Time or visit our website at www.SHIPLTC.com.

Thank you for allowing us the opportunity to serve your long-term care insurance needs.

Claim Forms

Policyholder Claim Form
Authorization for Use of Health-Related Information Form
Authorization for Disclosure of Health-Related Information Form

Please submit all of these forms together. Please be aware that the Authorization for Disclosure of Health-Related Information Form is only required if you would like us to be able to speak to someone other than you about your care. Otherwise, that form does not need to be returned. **No benefits will be provided until itemized invoices are received by us from either the policyholder or the caregiver(s). We will not be obtaining invoices on your behalf.**

Completed forms should be mailed or faxed to:

Senior Health Insurance Company of Pennsylvania
P.O. Box 64913
St. Paul, MN 55164
Fax: 952-983-5256

Senior Health Insurance Company of Pennsylvania

POLICYHOLDER CLAIM FORM

1. List ALL policy numbers under which you want to file a claim:
   Policy Number:_____ Policy Number: _____
   Policy Number:_____ Policy Number: _____
2. Policyholder's Name (Claimant):_____ Social Security #:_____-_____-_____
   Date of Birth:___/___/_____(MM/DD/YYYY) Gender: ❑ MALE ❑ FEMALE Phone Number: (___)____- _____
   Current Address:_____ City:_____ State:_____ Zip: _____
   What type of residence is this? ❑ Private Residence ❑ Nursing Home
   ❑ Assisted Living Facility ❑ Other: _____
3. Address to which all policy correspondence, including claim payments, should be mailed:
   ❑ Same as above ❑ Address shown below:
   Address:_____ City:_____ State:_____ Zip: _____
4. Cause or condition that caused you to require long-term care services: ❑ Sickness ❑ Accident
   _____
   _____
5. Date of the onset for this sickness or accident:___/___/_____(MM/DD/YYYY)
6. Is this claim related to an accident and someone else appears to be at fault? ❑ YES ❑ NO
7. Date you first sought treatment for this condition:___/___/_____(MM/DD/YYYY)
   Name of first treating physician: _____
   Address:_____ City:_____ State:_____ Zip: _____
   Phone Number: (_____)_____-_____ Fax Number: (_____)_____- _____
8. Is the physician above your family or primary care physician? ❑ YES ❑ NO
   If NO, please provide your family or primary care physician information:
   Family/Primary Care Physician Name: _____
   Address:_____ City:_____ State:_____ Zip: _____
   Family/Primary Care Physician Phone Number: (_____)_____-_____Fax Number: (_____)_____- _____
9. Privacy Laws restrict the information we can release to anyone other than the policyholder.
   NOTE: IF YOU HAVE DESIGNATED A POWER OF ATTORNEY, PLEASE ATTACH THE DOCUMENTATION.
   Have you designated a POWER OF ATTORNEY? ❑ YES ❑ NO
   Primary person to whom you have given POWER OF ATTORNEY: _____
   Home Number: (_____)_____- _____ Office: (_____)_____- _____ Cell: (_____)_____- _____
   IF YOU HAVE DESIGNATED SOMEONE TO ACT ON YOUR BEHALF IN FILING THIS CLAIM, PLEASE ALSO COMPLETE THE "AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION" FORM.
   Have you designated someone to act on your behalf? ❑ YES ❑ NO
   Person designated to act on your behalf in filing this claim: _____
   Home Number: (_____)_____- _____ Office: (_____)_____- _____ Cell: (_____)_____- _____

Senior Health Insurance Company of Pennsylvania

POLICYHOLDER CLAIM FORM

10. Agency/Facility/Provider Name:_____ Provider Tax ID Number: _____

    Address:_____ City:_____ State:_____ Zip: _____

    Phone Number: (_____)_____-_____ Fax: (_____)_____-_____ Cell: (_____)_____- _____

    NOTE: PLEASE ATTACH COPIES OF THE LICENSE OR CERTIFICATION, IF AVAILABLE.

11. Start of care date:___/___/_____(MM/DD/YYYY) End of care date:___/___/_____(MM/DD/YYYY)

12. Was any period of the patient's care covered by Medicare? ❑ YES ❑ NO

    If YES, please list the dates: _____

13. Was the care preceded by a hospital stay? ❑ YES ❑ NO

    If YES, please provide admission and discharge dates: _____

    Hospital Name: _____

    Address:_____ City:_____ State:_____ Zip: _____

    Phone Number: (_____)_____-_____ Fax Number: (_____)_____- _____

14. Since the date care started, have there been any breaks in care? ❑ YES ❑ NO

    If YES, please provide explanation and dates:

    _____

    _____

    _____

    _____

Before signing this form, please read the Claim Fraud Warning Statements for the state where the insurance policy was issued.

By signing below, I declare that all of the answers given are complete and true to the best of my knowledge and belief. I understand that Senior Health Insurance Company of Pennsylvania reserves the right to require further proof. By signing below, I agree that I have read and understand the applicable Claim Fraud Warning Statements.

Policyholder or Legal Representative Signature:_____ Date: _____

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The fraud warnings listed below are applicable to those policyholders with policies issued in the states and/or territories of AL, AK, AZ, AR, CA, CO, DE, DC, FL, ID, IN, KY, LA, ME, MD, MN, NH, NJ, NM, NY, OH, OK, OR, PA, PR, RI, TN, TX, VA, WA, and WV. Please review the fraud warning applicable to you before submitting a claim.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR, LA, RI, TX and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE, FL, ID, IN and OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH: Any person who, with a purpose to injure, defraud 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.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties

NM: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement material to the risk may be guilty of insurance fraud.

OR: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement material to the risk may be guilty of insurance fraud.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

AUTHORIZATION FOR USE OF HEALTH-RELATED INFORMATION

(This authorization complies with HIPAA Privacy Rules.)

Name of Policyholder:	Policy Number:
Address Line 1:	Address Line 2:
City, ST, Zip:	Date of Birth: _____/ _____/ _____

NOTE: If this form is completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship or similar documentation must accompany this form.

Use of Health-Related Information *to* Senior Health Insurance Company of Pennsylvania (In Rehabilitation)

I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, pharmacy, pharmacy benefits manager, federal, state or local government agency, insurance or reinsuring company, third-party claims administrator, consumer reporting agency, employer, Medical Information Bureau (MIB) or any other organizations, institutions or persons with knowledge or records of me and my health, including but not limited to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to Senior Health Insurance Company of Pennsylvania (In Rehabilitation) ("the Company"), or its legal representative. I understand that information obtained by use of this authorization, including individually identifiable health information, may be used for the purpose of administering my insurance benefits and/or making eligibility, risk or claim determinations, and that this information may be transferred to any organization or person employed by or representing the Company to assist with this purpose. I understand that information disclosed under this authorization may include medical records and reports concerning my physical or mental health and any and all associated diagnoses, prognoses, care or treatments, diagnostic and laboratory tests, prescription drug information and history, and information regarding drug use, alcoholism, mental illness, sexually transmitted diseases, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company or their authorized administrator and may no longer be protected by the same rule that applied in the first instance. This authorization is valid while my claim is pending, while it remains active or in order for the Company to process my appeal or administer benefits. Except in the case of an appeal, this authorization shall expire on the date my claim ends or seven years from the date of my signature below, whichever is later. I understand that my authorized representative or I have the right to request and receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

I understand that my authorization is voluntary and that I can refuse to sign this authorization. I do understand, however, that failure to sign this authorization may impair the Company's ability to evaluate my claim and may be a basis for denying a claim for benefits. I further understand that I have the right to revoke this authorization by notifying the Company in writing at Senior Health Insurance Company of Pennsylvania (In Rehabilitation), *Attn: Claim Review,* PO Box 64913, St Paul, MN 55164. Such revocation may be the basis for denying benefits.

IMPORTANT: Policyholder (or Legal Representative)

Signature: X _____ Date: _____

Type of authority to act on behalf of the insured (please check box, if applicable):

Legal Representative Power of Attorney Guardianship Conservatorship

AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION

(This authorization complies with HIPAA Privacy Rules.)

Name of Policyholder:	Policy Number:
Address Line 1:	Address Line 2:
City, ST, Zip:	Date of Birth: _____/ _____/ _____

NOTE: If this form is completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship or similar documentation must accompany this form.

Health Information to be Disclosed *by* Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
I authorize the Company to disclose my Protected Health Information to the following

(Person/Organization Receiving Information):_____

_____

The Relationship of this person/organization to me is: _____

This recipient may use the health information authorized on this form for the following purpose(s):

_____

_____

This authorization shall be effective as of the date of my signature below. I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by giving written notice to: Senior Health Insurance Company of Pennsylvania (In Rehabilitation)*, Attn: Claim Review,* PO Box 64913, St Paul, MN 55164. I understand that the Company may not deny me benefits due to refusal to sign this authorization. I further understand that my signature on this form does not authorize any changes to my policy information or to my policy or change the way the Company communicates with me. I also understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The undersigned is entitled to receive a copy of this form. A photocopy of this authorization shall be as valid as the original.

Policyholder (or Legal Representative)

Signature: X _____ Date: _____

Type of authority to act or sign on behalf of the policyholder (please check box, if applicable):

☐ Legal Representative ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship

Senior Health Insurance Company of Pennsylvania

DIRECTION TO PAY FORM

Instructions: *Please complete and sign this form if you and your provider have agreed to establish a Direction to Pay. You must first establish if the provider is willing to consider this Direction to Pay. The service provider will need to submit their Tax Identification Number (Social Security Number if service provider is an independent provider) and attach a completed W-9 form so the payments will be made directly to the service provider.*

The Direction to Pay will not be in effect until Senior Health Insurance Company of Pennsylvania has received the completed form. The Direction to Pay may be terminated in the future upon receipt of a written request stating you or the provider wishes to revoke the Direction to Pay.

You may return the completed form via fax to 952-983-5256 (preferred) or mail to: Senior Health Insurance Company of Pennsylvania, P.O. Box 64913, St. Paul, MN 55164.

Claimant Name: _____
Policy Number: _____

I, _____ , the Claimant or the guardian or other legal Representative of the Claimant (legal documentation of guardianship or other representative capacity, if appropriate, is attached), hereby authorize direct payment to _____ (provider) of any long-term care benefits otherwise payable to or on behalf of the Claimant for the services provided at a rate not to exceed the Provider's regular charges. 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 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. This Direction to Pay is valid for Senior Health Insurance Company of Pennsylvania.

_____ _____ *Service Provider Representative Signature* *Date*	_____ _____ *Claimant/Legal Representative Signature* *Date*
_____ *Printed Name of Service Provider Representative*	_____ *Printed Name of Claimant/Legal Representative** **If you are signing as a legal representative, describe the scope of your authority to act on the Claimant's behalf and include a copy of the documentation of your legal authority.*

Provider's Federal Tax ID Number/Social Security Number: _____

_____
Name of Service Provider

_____
Street Address City State Zip Code

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▸ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▸ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▸

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▸ **Date** ▸

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

CAREGIVER WEEKLY TIMESHEET

Return Forms to:
Senior Health Insurance
Company of Pennsylvania
P.O. Box 64913
St. Paul, MN 55164

Insured:

Policy Number:

CAREGIVER INSTRUCTION

1. Complete a new timesheet each week.
2. Indicate in EVERY box EACH day the level of assistance provided ON THAT DAY using the Charting Key to the right.
3. Enter the start & end times, number of hours worked, and total pay EVERY day along with a weekly total pay at the end.
4. Write a daily note describing the insured's care needs, problems, appointments, important events, or change in condition.
5. Print your name, relationship to insured, sign, and date the completed form

CHARTING KEY
X = Not done today
I = Insured performed task Independently
S = Supervise/ Standby Assist within arm's reach
A =Hands-on Assistance required to complete task

Activity Date	Reimbursement Rate $____/ Hour or Day	Feed	Bath	Dress	Toilet / Continent	Walk/ WC	Transfer	Meds	Meal Prep	Clean & Laundry	Shop & Transport
Monday	Time In										
___/___/___	Time Out	Daily Note									
	Total # Hrs										
	Mon Pay $										
Tuesday	Time In										
___/___/___	Time Out	Daily Note									
	Total # Hrs										
	Tues Pay $										
Wednesday	Time In										
___/___/___	Time Out	Daily Note									
	Total # Hrs										
	Wed Pay $										
Thursday	Time In										
___/___/___	Time Out	Daily Note									
	Total # Hrs										
	Thurs Pay $										
Friday	Time In										
___/___/___	Time Out	Daily Note									
	Total # Hrs										
	Fri Pay $										
Saturday	Time In										
___/___/___	Time Out	Daily Note									
	Total # Hrs										
	Sat Pay $										
Sunday	Time In										
___/___/___	Time Out	Daily Note									
	Total # Hrs										
	Sun Pay $										

TOTAL WEEKLY PAY **$**_____ Caregiver relationship to Insured: _____Caregiver SSN#:_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO OMIT ANY FACTS I KNOW ARE IMPORTANT

Print Caregiver Name _____ Signature _____Date_____

****

INSURED / REPRESENTATIVE INSTRUCTIONS:

1. Verify the accuracy of the services provided and reimbursement information above.
2. Complete the form with your name, date, and signature

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO OMIT ANY FACTS I KNOW ARE IMPORTANT

Print Insured / Legal Representative Name _____ Signature _____ Date _____

If you have any questions, please call 877-450-5824

Senior Health Insurance Company of Pennsylvania

CONTINUED MONTHLY RESIDENCE FORM

Instructions:

- *The Continued Monthly Residence (CMR) form is a required part of the monthly claim submission and must be completed thoroughly by facility staff.*
- *Ensure copies of current BLANK CMR forms are maintained by the facility.*
- *Complete a form for each month, on or after the last day of the month, after the services have been provided. (Example: Facility charges from June 1st-June 30th should not be submitted prior to July 1st).*
- *Submit with a copy of the facility's invoice reflecting room and board charges for the service period.*
- *Incomplete forms and photocopies of a prior month's completed CMR form will be considered ineligible and may delay the reimbursement process.*

Please complete the form and submit monthly via fax to 952-983-5256 (preferred), or mail to: Senior Health Insurance Company of Pennsylvania, P.O. Box 64913, St. Paul, MN 55164.

Facility Name: _____
Facility Address: _____
Facility City/State: _____
Facility Phone #: _____
Facility Fax #: _____

Resident Name: _____
Resident Policy #: _____
Resident Room #: _____
Resident Move-In Date: _____
Month of Service: From _____ Through_____

1. **Has the resident remained in the same room/apartment for the entire month?** ❑ Yes ❑ No
   If no, provide prior room/apartment #: _____

2. **Select the level of care that describes the resident's current room, unit or apartment:**
   - ❑ Alzheimer's/Dementia unit (secured)
   - ❑ Alzheimer's/Dementia unit (non-secured)
   - ❑ Assisted living unit (secured)
   - ❑ Assisted living unit (non-secured)
   - ❑ Independent living apartment or unit
   - ❑ Skilled Nursing Facility
   - ❑ Intermediate Care Facility

3. **At any time during this service period, was the resident away from the facility overnight for any reason?** ❑ Yes ❑ No
   If yes, provide dates: Departure Date: _____ Return Date: _____
   Provide reason for absence: _____
   If absence was a hospital stay, provide dates: Admission Date: _____ Discharge Date: _____

4. **Is Medicare, Medicaid/MediCal or any other insurance providing benefits for expenses incurred during this service period?**
   - ❑ No
   - ❑ Yes, **Medicare**, provide a copy of the Explanation of Medicare Benefits (EOMB); UB-04 form or other proof of remittance by Medicare or Medicare intermediary; and provide dates of 100% coverage/coinsurance coverage:
     _____
   - ❑ Yes, **Medicaid/MediCal**, provide the contact information for Medicaid/MediCal Case Worker:
     Case Worker Name: _____
     Phone Number: _____ Fax Number: _____
     Medicaid/MediCal office: _____
   - ❑ Yes, **other insurance coverage** information:
     Insurer Name: _____ Policy Number: _____
     Insurer Address: _____ Phone Number: _____

By signing below, I declare that all of the answers given are complete and true to the best of my knowledge and belief.

_____

Print Name *Title* *Phone Number*

_____

Signature *Date*

By reviewing this **Claim Information Package** you have taken the first step in initiating a new claim submission. This package comes with all the information you will need to help you get the claim filing process started. Below are more **frequently asked questions** about filing a new claim under your long-term care insurance policy.

Q. What claim forms must be completed for every claim?
A. The required forms are included within this Claim Information Package. Complete the first two pages of the Claim Form as well as the **Authorization for Use of Health-Related Information Form.** Also complete the **Authorization for Disclosure of Health-Related Information Form** if you want to authorize anyone other than the policyholder to speak with us about your claim. Please submit all of these forms to us together. PLEASE ALSO MAKE SURE THAT ITEMIZED INVOICES ARE SUBMITTED TO US. If you are filing a Home Health Care claim, the enclosed Caregiver Weekly Timesheets may be used if your provider does not supply them.

Q. Is there any information, other than claim forms, needed to make a claim determination?
A. Once we receive completed claim forms, it may be necessary for us to obtain additional documentation to make an accurate determination of eligibility for benefits. The additional documentation may include, but is not limited to, physician and hospital records, the provider's license (if applicable) and care provider notes. In all cases itemized bills must be submitted to us for benefits to be provided. It is very important to make copies of all correspondence being sent in to file the claim so that you have a record of what you have submitted. Please refer to the appropriate enclosed initial claim checklist for detailed guidance on completing the claim forms, as well as, the additional documentation we may need.

Q. Who completes the claim form?
A. We request that the policyholder or legal representative fully complete the **Policyholder Claim Form** and the **Authorization for Use of Health-Related Information Form.** The policyholder or legal representative should also complete the **Authorization for Disclosure of Health-Related Information Form** if you want to authorize us to speak to anyone other than the policyholder about this claim. Be sure to return these documents to us at the same time.

Q. What is a Direction to Pay form?
A. A Direction to Pay form allows us to pay your care provider directly. This is not a permanent assignment of policy benefits; you have the right to change your mind at any time in the future. This form is only required if you would like us to send any payable benefits directly to your provider. In order to assign benefits, please be advised that we will only accept the Direction to Pay Form. In addition, your provider must send us a completed W-9 form (required by the IRS).

Q. Where can I get more claim forms?
A. Claim forms can be obtained by contacting our Customer Service team. You can also download claim forms from our website, www.SHIPLTC.com

Q. Who can answer questions or concerns about the status of a claim or the claim process?
A. Our Customer Service Representatives will be happy to clarify policy benefits and explain the claim process, although some privacy regulations may apply. If you have questions regarding a claim, please contact us at the telephone number listed on the bottom of each claim form.

Q. Where should I send the completed claim forms?
A. Our mailing address and fax number are located on the bottom of each claim form and on the initial claim checklist.

☑ Nursing Facility / Assisted Living Facility Initial Claim Checklist

Check off each item as you complete it to help you keep track of your claim submission

(this checklist is for your convenience only and does not need to be returned to us)

To Do: POLICYHOLDER

- ❑ Claim Form: Complete All of the Questions 1 – 14
- ❑ Authorization for Use of Health-Related Information Form
- ❑ Authorization for Disclosure of Health-Related Information Form, if you would like us to be able to speak to someone other than you about your care. Otherwise, this form does not need to be returned
- ❑ Direction to Pay Form (Required If Directing Benefit Payments to Provider)

To Do: OTHER FORMS

- ❑ Nursing Home / Assisted Living Facility License (If Available)
- ❑ Minimum Data Set (MDS) or Nursing Assessment
- ❑ Plan of Care or Service Plan (If Available)
- ❑ Itemized Invoice must be submitted by the policyholder, caregiver or facility for any benefits to be provided by us
- ❑ Continued Monthly Residence form must be completed thoroughly by facility staff each month, on or after the last day of the month, after the services have been provided and submitted for any benefits to be provided by us.
- ❑ Medication List and Physician's Medication Order (If Applicable)

IMPORTANT: PLEASE MAKE PHOTOCOPIES OF ALL CLAIMS MATERIALS AND RETAIN FOR YOUR RECORDS!

MY NOTES:

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❑ Mailed on____/____/____To:

Senior Health Insurance Company of Pennsylvania
P.O. Box 64913
St. Paul, MN 55164

❑ Faxed on____/____/____To:

Fax: 952-983-5256

☑ Home Health Care Initial Claim Checklist

Check off each item as you complete it to help you keep track of your claim submission

(this checklist is for your convenience only and does not need to be returned to us)

To Do: POLICYHOLDER

- ❑ Claim Form: Complete All of the Questions 1 – 14
- ❑ Authorization for Use of Health-Related Information Form
- ❑ Authorization for Disclosure of Health-Related Information Form, if you would like us to be able to speak to someone other than you about your care. Otherwise, this form does not need to be returned
- ❑ Direction to Pay Form (Required If Directing Benefit Payments to Provider)

To Do: OTHER FORMS

- ❑ Caregiver Certification / Nursing License (If Available)
- ❑ Home Health Agency License (If Available)
- ❑ Plan of Care or Nursing Assessment (If Available)
- ❑ Itemized Invoice must be submitted by the policyholder, caregiver or facility for any benefits to be provided by us
- ❑ Daily Visit Notes

IMPORTANT: PLEASE MAKE PHOTOCOPIES OF ALL CLAIMS MATERIALS AND RETAIN FOR YOUR RECORDS!

MY NOTES:

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❑ Mailed on___/____/____To:

Senior Health Insurance Company of Pennsylvania

P.O. Box 64913

St. Paul, MN 55164

❑ Faxed on____/____/____To:

Fax: 952-983-5256