GTL | GUARANTEE TRUST LIFE

SHORT-TERM HOME HEALTH CARE CLAIM FORM and Optional Riders

Please read the important information below:

- ☐ **This packet is used for filing for your Short Term Home Health Care or Rider Benefits.** Please be sure your policy number(s) is/are on all documents.
- ☐ **If you are filing ONLY for your Prescription Drug Benefits, please use just the Prescription Drug Filing Form** provided on the website, as all these additional forms and information are not required.
- ☐ The claim form must be completed and signed by the Insured or responsible party. **Please attach Power of Attorney or Guardian papers if applicable.**
- ☐ The **HIPAA Authorization** to Permit Use and Disclosure of Health Information must be signed, dated and included with your submission, so that we can contact your medical provider on your behalf for additional information needed.
- ☐ We will also need to obtain on your behalf the CarePlan and the HHC Agency licensing
- ☐ Include any **itemized bills** for consideration. We do not pay on any advanced billings. Include any Aide note(s) for your care. Please be sure you answer ALL questions on the claim form.
- ☐ If you are filing for **Caregiver Benefits** to receive support or resources from T-Care, please contact T-Care directly at 800-673-7905.
- ☐ Regardless of the benefits you are filing for, including the Caregiver benefits, the **Physicians Certification** Form must be completed and returned.

An itemized bill should contain:

1. The date(s) of treatment,
2. The type(s) of service,
3. The diagnosis,
4. The medical provider's name and address,
5. The individual charge for each expense.

☐ Please send all information to:

Guarantee Trust Life Insurance
P.O. Box 1144
Glenview, Illinois 60025
OR Fax to: (847) 699-1048
OR Email to: Claims@gtlic.com

NOTE: Your Policy may have a Pre-Existing Conditions Limitation and a 2 Year Policy Contestability Period. If your claim happened during one of these periods, additional information may be required. If we need to request any additional information and we have your signed HIPAA Authorization, we will handle these requests directly with your medical provider(s) and will notify you of our action and any delays.

- If you signed a benefits assignment with the provider and you have a balance still due, we are required to pay that balance directly to them; otherwise, benefits will be sent to you.
- **Processing delays may result if you do not provide all the above information.**
- We suggest you make photocopies of any information sent for your own records.

SKIP THE CALL. CHAT WITH US INSTANTLY!

*Access your policy information anytime in the Customer Portal and check your claim status **instantly** with our 24/7 chatbot.*

Visit gtlic.com and click Policy Login in the navigation.

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Mail claims to:
P.O. Box 1144
Glenview, Illinois 60025
Or fax to: (847) 699-1048
For Customer Service, please call: (800) 338-7452

SHORT-TERM HOME HEALTH CARE CLAIM FORM and Optional Riders

TO BE COMPLETED BY THE INSURED

Policy Number(s) _____ Policyholder's Name _____

Claimant/Patient Name _____ Date of Birth _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Phone _____ Email _____

TYPE OF BENEFIT(S) FOR WHICH THE CLAIM IS BEING MADE

- ☐ Skilled/General Nursing Care (RN/LPN/LVN)
- ☐ Physical Therapy
- ☐ Speech Pathology
- ☐ Occupational Therapy
- ☐ Chemotherapy Specialist
- ☐ Enterostomal Therapy
- ☐ Respirational Therapy
- ☐ Medical Social Services

Optional Rider Benefits:

☐ Accident or Sickness Hospitalization ☐ Ambulance ☐ Critical Accident–go to page 3

Date symptoms first appeared: ___/___/___ Date of first visit with physician: ___/___/___

Date of actual/definitive diagnosis: ___/___/___

Have you ever had this illness/condition before? ☐ Yes ☐ No If yes, date? ___/___/___

If yes, what's the name, address and telephone number of physician? _____

If hospitalized for this illness/condition, what's the name and address of hospital/medical center? _____

Are you now, or have you received home health care services before? ☐ Yes ☐ No If yes, when: ___/___/___

What condition were/are you receiving care for? _____

Have you ever been diagnosed with a cognitive illness? What diagnosis: _____ When: ___/___/___

Your Primary Care (family doctor) name, address and telephone number: _____

Where there any OTHER PHYSICIANS seen during the last two (2) years? If so, please provide their names, addresses and phone numbers. If more space is needed, please attach separate sheet.

Physician name _____ type of doctor _____ address and phone number _____

Physician name _____ type of doctor _____ address and phone number _____

Physician name _____ type of doctor _____ address and phone number _____

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SHORT-TERM HOME HEALTH CARE CLAIM FORM and Optional Riders

TO BE COMPLETED FOR AN ACCIDENT CLAIM

Date of accident: ____/____/____ Time of accident: _____AM _____PM

Location of accident: _____ Work related?: ☐ Yes ☐ No

What was your injury?: _____ Did you suffer a fracture or break?: ☐ Yes ☐ No

Was this a sports related accident? ☐ Yes ☐ No If yes, what sport? _____

Description of accident: _____

Were you treated in an Emergency Room or Immediate Care Facility? ☐ Yes ☐ No

If yes, please provide date and the name and address of the facility: Date ____/____/____

Name and address of facility: _____

Were you admitted as an inpatient for your injuries: ☐ Yes ☐ No

Please provide the name, address and telephone number of physician(s) who treated you:

Physician name Address Phone Number

SIGNATURE FOR CLAIM PACKET

Is Medicaid involved in the coverage of your care or medical expense? ☐ Yes ☐ No

<u>If yes</u> and Medicaid is involved in the coverage of my expenses, I HEREBY AUTHORIZE Guarantee Trust Life Insurance Company to coordinate benefits related to my bills directly with the Hospital or Medical Provider. I understand that I am financially responsible for any charges not covered by the policy.

In addition, I understand that this claim form information will be used by Guarantee Trust Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of the authorization upon request.

Insured Member Signature **Print Name** **Date**

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PHYSICIAN'S HOME HEALTH CERTIFICATION

1. Policy No.

4. Certification Period
From: To:

2. Patient's Name and Address

5. Physician's Name and Address

6. Physician's Tax I.D. No.

3. Date of Birth: Sex: ☐ M ☐ F

7. ICD-10-CM	Principal Diagnosis	Date
8. ICD-10-CM	Other Pertinent Diagnosis	Date

9. Prior Hospital Confinement for which Subsequent Home Health Care was needed:
A. From: To:
B. Name of Hospital and Address

10. Can the patient perform any of the following Activities of Daily Living (ADLs) without the assistance of another person?

YES NO

A. ☐ ☐ Bathing (getting in and out of the bathtub or shower, utilizing normal bathroom facilities that have been equipped with railings and steps);
B. ☐ ☐ Continence (bladder control);
C. ☐ ☐ Dressing (tying shoes, buttoning buttons or clasps);
D. ☐ ☐ Eating (consuming food or drink or utilizing utensils appropriate for the patient's physical condition and which are placed within reach);
E. ☐ ☐ Toileting (maintaining adequate bathroom hygiene and toilet habits); or
F. ☐ ☐ Transferring to and from bed or chair

If any of the above are answered "NO," please furnish test results.

11. Does the patient require continuous supervision and assistance due to a Cognitive Impairment (a deficiency in the ability to think, perceive, reason, and/or remember, which has been evaluated and measured through clinical evidence and standardized tests)?

YES ☐ **NO** ☐ If "YES," please furnish test results.

12. Home health services performed:

- ☐ Skilled Nursing (Skilled nursing care provided by a registered nurse [RN])
- ☐ General Nursing (General nursing care provided by a licensed practical nurse [LPN] or licensed vocational nurse [LVN])
- ☐ Physical Therapy
- ☐ Speech Pathology
- ☐ Occupational Therapy
- ☐ Chemotherapy Specialist Services
- ☐ Enterostomal Therapy
- ☐ Respirational Therapy
- ☐ Medical Social Services
- ☐ Home Health Care Aide (any individual, other than a member of the patient's immediate family, working under the supervision of an RN, who is qualified, by training and experience, to provide assistance with the Activities of Daily Living listed in 6 above and has been certified by the appropriate regulatory authority).
- ☐ Other (specify) _____

13. Other Remarks: _____

14. I ☐ certify ☐ recertify that the above statements are true and correct and are based on standard medical tests I have performed and that the above home health services were/are required during the period of certification.

15. Certifying Physician's Signature _____ Date Signed _____

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ASSIGNMENT OF BENEFITS

If you wish to have benefits paid to you, there is no need to complete this form. The Assignment of Benefits Designation is ONLY necessary if you are assigning the payment of your Caregiver Lump Sum benefits directly to another.

Insured Name: _____ For Policy Number:_____

☐ Yes, I would like to assign the payment of my Caregiver Lump Sum benefits to another.

I, the undersigned, irrevocably assign to the below designated named assignee, all my rights and benefits under the Caregiver Lump Sum Benefit. I understand that this document is a direct assignment of my rights and benefits that would otherwise be payable to me.

Designated Assignee Name: _____

Assignee Payment Address: _____
(No P.O. Box) Street City State Zip Code

How do you know the Assignee? _____

.....

Signature if Assignee accepting payments: _____

Assignee SS#: _____ Assignee Date of Birth: _____/_____/_____

**Please be advised that there are potential tax implications for the Caregiver Benefit being paid to the Assignee. Prior to selecting benefits to be paid to an Assignee, such a person should be aware of the potential tax consequences and advised to consult with a personal tax advisor. Guarantee Trust Life Insurance Company or its agents cannot provide advice about this. Receiving these assigned benefits will require a 1099 for taxes.*

Print Name of Insured/or Person Legally Responsible:_____ Date: _____/_____/_____

Signature of Insured/or Person Legally Responsible:_____ Date: _____/_____/_____

If you are person legally responsible, state relationship to Insured:_____**
** Power of Attorney papers will be required.

This Assignment of Benefits Designation will remain in effect for this one-time Caregiver Lump Sum payment. If there is such time that a restoration of benefits is approved and an additional Caregiver benefit is requested a new Assignment for will need to be completed.

Guarantee Trust Life Insurance Company
P.O Box 1144, Glenview, Illinois 60025
1-800-338-7452

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information to process a claim for benefits.

Policy/Certificate # _____

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to GTL, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent GTL has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits.

I understand that GTL may condition payment of a claim upon my signing this Authorization if the disclosure of information is necessary to determine the level or validity of the claim payment. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of GTL to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to GTL pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

(Print Please) Name of Patient _____ Date of Birth _____

Signature of Patient _____ Date _____

(Please Print) Name of Authorized Representative, or Next of Kin _____

Relationship of Authorized Representative or Next of Kin to Patient _____

Signature of Authorized Representative or Next of Kin _____ Date _____

Dear Insured: *Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.*

Connecticut
Georgia
Hawaii
Iowa
Illinois
Kansas
Massachusetts
Michigan
Missouri
Mississippi
Montana
Nebraska
North Carolina
North Dakota
Nevada
South Carolina
South Dakota
Utah
Vermont
Wisconsin
Wyoming

General Fraud Warning (to be used for above states only) Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama – 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.

Alaska – 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.

Arizona - 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.

Arkansas, Louisiana, Rhode Island and West Virginia – 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.

California – For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado – 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.

Delaware – 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.

District of Columbia – 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.

Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – A 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.

Maine – 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.

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

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

New Hampshire – 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.

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

New Mexico – 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 CIVIL FINES AND CRIMINAL PENALTIES.

Ohio and Oregon – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Tennessee, Virginia and Washington State – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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.