All Heart HOME CARE

WHEN AND HOW TO UTILIZE YOUR LONG-TERM CARE INSURANCE

6 ESSENTIAL POINTS

WHEN IS THE RIGHT TIME TO FILE A CLAIM?

It's best to initiate a claim as soon as the insured individual becomes eligible and requires assistance. Doing this ensures the benefits are utilized effectively. Eligibility typically falls into 2 categories: physical and cognitive conditions. Those with cognitive impairments may qualify based on the need for "constant safety monitoring." Clients dealing with chronic illness, disability, or physical injury often require assistance with at least 2 activities of daily living (ADLs), such as bathing, dressing, transferring, toileting, or feeding.

WHAT IS THE ELIMINATION PERIOD?

Most policies have an elimination period ranging from 14 to 120 days before coverage begins. It's crucial to understand the specifics of this waiting period, as you'll be responsible for any expenses incurred during this time. Be sure to clarify whether the elimination period is based on calendar days or on specific days of care.

HOW DO I FILE A CLAIM?

The first step is to contact your long-term care insurance provider or visit their website to request a claim packet. Be prepared to provide essential details such as the insured person's name, birthdate, policy number, social security number, and diagnosis or condition. It's also important to inquire about the elimination period, as well as any daily, weekly, or monthly coverage limits or benefits.

WHAT DOCUMENTS ARE NEEDED FOR THE CLAIM PROCESS?

A claim approval process is typically multi-step. You'll generally need to complete a claim packet, submit medical records, provide a nursing or medical assessment, and obtain a physician's statement confirming the insured's needs. If someone else is helping with the claim, they may need to provide a Power of Attorney or HIPAA waiver. The insurance company might also require documentation from the homecare or home health agency, such as proof of licensure. Once the claim is approved, you will need to submit invoices and care documentation.
All Heart Home Care specializes in billing and care documentation for long-term care insurance claims.

WHAT IF MY CLAIM IS DENIED?

The most common reason for long-term care denials is errors in paperwork, such as incomplete or missing forms. If your claim is denied, carefully review the denial letter and correct any mistakes promptly. All Heart Home Care is skilled in advocating for clients and has a strong track record of successfully submitting claims. If you believe the denial was a mistake and wish to challenge it, follow the dispute process outlined by the insurance company, consider consulting an elder law attorney, or reach out to your state's insurance ombudsman or commissioner.

HOW ARE PAYMENTS MADE ONCE THE CLAIM IS APPROVED?

There are two primary ways to manage payments to providers through long-term care benefits. One option is the assignment of benefits, where the insurance company pays the care agency directly. Alternatively, the client or their family can pay for care upfront and be reimbursed by the insurance provider. Regardless of the payment method, a reputable agency like All Heart Home Care ensures accurate charting and billing practices to meet the policy's requirements continuously.

LET US HELP YOU MAXIMIZE YOUR LONG-TERM CARE INSURANCE BENEFITS

All Heart Home Care offers a complimentary needs assessment and will thoroughly review your long-term care insurance policy. We assist in preparing the necessary documentation to file your claim and help you understand the daily, weekly, or monthly coverage limits. Since 2014, we've been helping families access reliable, high-quality home care through long-term care insurance policies designed for this purpose.