Informal Caregiver Invoice

Instructions

1. Enter the insured's claim ID and name, as well as the informal caregiver's name.
2. Enter one date of service per line.
3. Complete the time in and time out for that calendar day. Include a.m. and/or p.m., and round time to the nearest quarter hour.
4. Enter the total hours, approved hourly charge (per plan of care), and daily total for each date of service.
5. Enter the total reimbursement amount requested.
6. Mark an "X" in the correct box for each activity of daily living service provided per line.
   - Please note: *Eating* refers to providing assistance with getting food into the insured's mouth or assistance with a feeding tube or intravenous feeding. It does not mean providing assistance with meal preparation. *Transferring* means providing assistance with getting out of a bed, chair, or wheelchair. It does not mean providing transportation to the insured.
7. Enter the check or transaction number that corresponds with each date of service and attach the appropriate proof of payment. Accepted proof of payment includes:

Canceled personal, business, substitute, or cashier's checks

The following is required:

- image of the front and back of the check
- bank name and routing number present on the front of the check
- valid bank stamp (ink imprinted and/or electronic)
- substitute checks must also include a disclosure statement indicating that the check is a legal copy of the original

Please note: We do not accept carbon copies or duplicate checks, copies of uncashed checks, or copies of check registers as proof of payment.

eStatements and online bill pay receipts

The following is required:

- bank name or logo
- payee name
- remitter name
- posted or cleared date
- check number (this does not apply to electronic funds transfers or wires)
- payment amount
- corresponding reduction in account balance (this does not apply to online bill pay receipt)

Money orders or payroll payments

- In all cases, payment must be made after services are rendered.
- Payments made by cash or checks made out to cash are not reimbursable.
- The invoice total and proof of payment amount must match.

8. The informal caregiver must sign and date the invoice after services are rendered.
9. The insured or the insured's legal representative must sign and date the invoice after services are rendered.
10. If the informal caregiver and legal representative who sign the form on behalf of the insured are the same person, then an additional signature is required by a third-party to attest to the services rendered, hours worked, and payment made. **Note:** Handwritten signatures are required.
11. Visit **LTCFEDS.com** to download more invoices.

Please return your completed invoice and proof of payment by email to **claimsinfo@ltcpartners.com,** by fax to **1-866-513-2674,** or by mail to **Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797**.

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, and administered by Long Term Care Partners, LLC.

John Hancock OPM.GOV

The Federal Long Term Care Insurance Program™

Informal Caregiver Invoice

Claim ID

Insured's name

First name M.I. Last name

Informal caregiver's name

First name M.I. Last name

Informal caregiver's relationship to the insured

Date (mm/dd/yy)	Time in (indicate a.m. or p.m.)	Time out (indicate a.m. or p.m.)	Total hours	Approved hourly charge	Daily total
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

Description of services provided:

☐ Bathing ☐ Dressing ☐ Toileting ☐ Supervision/safety
☐ Continence ☐ Eating ☐ Transferring ☐ Other _____

Total paid $

Amount to reimburse $
☐ Taxes included
☐ Partial

Check or transaction numbers: _____

☐ **I have enclosed proof of payment (outlined on the back of this invoice).**

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.

Sign and date after services are rendered.

Informal caregiver's signature

_____ (Required) **Date signed** ____ / ____ / ____ (Required: mm/dd/yy)

Insured's or legal representative's signature

_____ (Required) **Date signed** ____ / ____ / ____ (Required: mm/dd/yy)

Additional signature

_____ **Date signed** ____ / ____ / ____ (Required: mm/dd/yy)

If there is more than one legal representative that must act jointly, then all representatives must sign.