Prudential

The Prudential Insurance Company of America
PO Box 8519, Philadelphia, PA 19176-8519
Tel 800-732-0416 Fax: 877-874-6573

LONG TERM CARE INSURANCE CLAIM FORM

NOTE: Before completing the enclosed claim form - If you have not yet been assessed by Prudential to determine if you are eligible for benefits and you would like to initiate a claim, please call 800-732-0416 and ask to speak with a Benefit Access Counselor.

Filing Instructions

- ☐ Claims may be **faxed** to the attention of LTC Claims at **877-874-6573** or mailed to the address above.
- ☐ Complete Sections A, B and H in their entirety, then complete the appropriate section(s) for the type of claim you're filing (sections C through E)
- ☐ Only submit claims for past dates of service; not future dates of service.
- ☐ If you are claiming for Cash Benefits, you will need to use the Cash Benefits Claim form. If you need a Cash Benefits Claim form, please call us.
- ☐ If an independent health care professional or informal caregiver provided the services, you will need to use a Home Health Care Timecard. If you need a Home Health Care Timecard, please call us.
- ☐ Please be sure to enclose the invoice/statement for the item or service for which you are claiming benefits.
- ☐ Please include a copy of your provider's license with the initial claim submission.

A Insured Information

Name: (Mr./Mrs./Ms.) _____ Policy or Certificate #: _____

If Group coverage, Employer Name or Group Number _____

Presently Residing at: _____
Street (and Apt. #) or P.O.Box

_____
City, State Zip Code

Daytime Phone #: (_____) _____ - _____ Alternate Phone #: (_____)_____-_____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Do you have a Durable Power of Attorney, Conservator or Guardian? ☐ No ☐ Yes, If yes, please include a copy with your initial claim.

B Other Coverage Information

If you have an Explanation of Benefits Statement from another payer, please include with this claim submission.

☐ Yes ☐ No Is **Medicare** covering/has **Medicare** covered the item for which you are claiming?
If yes, list dates or amounts covered by **Medicare**: _____

☐ Yes ☐ No Are you a **Medicaid** recipient (public assistance)?

☐ Yes ☐ No Is there another insurer or organization providing any benefits for any of the items or services for which you are claiming? If yes, please list details below.
Other Payer Name: _____
Policy or I.D. No.: _____
Is this Group Coverage?_☐ Yes ☐ No

C Facility Care – Complete all information below and submit with an itemized bill for the services you are claiming. Please include a copy of the provider's license/certification with the initial claim.

☐ Nursing Home ☐ Assisted Living/Residential Care Facility ☐ Other Facility (describe): _____
☐ Hospice In/Patient ☐ Respite In/Patient

Date of Service: ____/____/____ To: ____/____/____
DATE REQUIRED DATE REQUIRED

Facility Name & Address	Facility TAX ID #	Facility Phone #	Facility Fax #

Was this patient absent from the facility during this period? ☐ No ☐ Yes If yes, list dates/reason:

_____

➔ _____ Date: ____/____/____
Signature of Authorized Facility Representative

D Home & Community – Complete all information below and submit with an itemized bill for the services you are claiming below. Please include a copy of the provider's license/certification with the initial claim.

☐ Home Health Care ☐ Adult Day Care ☐ Other (describe) _____
☐ Hospice At Home ☐ Respite At Home

Agency Name & Address	Agency TAX ID #	Agency Phone #	Agency Fax #

E Other Benefits - Complete all information below and submit with an itemized bill (except Restoration of Benefits) for the services you are claiming. Please include a copy of the provider's license/certification, where applicable, with the initial claim.

☐ Independence Support/Lifestyle Change/Home Support Services
☐ Private Care Manager
☐ Durable Medical Equipment
☐ Other (please describe) _____

☐ Restoration of Benefits: If available under my contract, I elect to restore the Lifetime Maximum at this time. To the best of my knowledge and belief, and by my signature below, I have satisfied the terms and conditions of coverage and wish to proceed with a reassessment to confirm that I am no longer Chronically Ill.

F Assignment of Benefits – Please complete only if you would like us to pay your provider directly

☐ ***I hereby direct my benefits be paid to:*** (list provider's name) _____
This assignment of benefits will be ongoing until I provide Prudential with written notice indicating otherwise:

➔ _____ Date: _____/_____/_____
Insured or his Legal/Representative Signature

G Mailing Address – Please complete only if you would like us to change your mailing address

☐ **CHECK this BOX if you would like to change your address of record and send all future Explanations of Benefits, renewal notices and correspondence related to this policy/certificate to:**

_____
Street (and Apt. #) or P.O.Box

_____
City, State Zip Code

FRAUD WARNING:

ARIZONA RESIDENTS - 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.

ALABAMA RESIDENTS - 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.

CALIFORNIA RESIDENTS - For your protection, California law requires the following to appear on this form. 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.

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.

DISTRICT OF COLUMBIA and RHODE ISLAND RESIDENTS –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

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

KENTUCKY RESIDENTS - 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.

MARYLAND RESIDENTS - 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.

NEW JERSEY RESIDENTS - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and/or civil penalties.

PENNSYLVANIA and UTAH RESIDENTS - 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO - 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 by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] 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.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA and WASHINGTON RESIDENTS - 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.

ALL OTHER STATES and TERRITORIES – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commissions of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

NEW YORK RESIDENTS: 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.

H ACKNOWLEDGMENT:

The information provided herein is accurate and correct to the best of my knowledge and belief.

I have reviewed the fraud warnings above.

➔ _____ Date: ____/____/____
Insured's or Legal Representative's Signature

NOTE: YOUR INSURANCE POLICY PLACES A TIME LIMIT WITHIN WHICH TO FILE CLAIMS; REFER TO YOUR POLICY FOR DETAILS.