5 Tips to Start a Long-Term Care Claim

John Hancock wants your long-term care insurance claim experience to be as positive as possible. Managing your claim online is convenient and secure. Register to create your account, access benefit information and additional resources, or start a claim at ltc.customer.johnhancock.com.

Start a claim as soon as you begin to need care

The first step in the claim process is for John Hancock to certify that you meet the benefit eligibility criteria outlined in your policy. A decision on benefit eligibility is usually made within 40 days of the claim initiation. Most policies define the benefit eligibility criteria in terms of your ability to perform certain activities of daily living or your level of cognitive function. The exact criteria varies by policy, so you will want to review this section of your policy closely.

In order to make this determination, John Hancock will provide you with a claim form that asks you a few questions about your functional/cognitive status and asks for contact information for your care providers. Based on your individual situation, the review may also involve an onsite assessment in your home or obtaining records from your care provider(s).

The provider eligibility process can begin as soon as you start a claim. Notify John Hancock immediately when a new care provider is used to minimize any processing delays. In order to prevent any delay in the eligibility review, please check the claim form and with your care provider(s) for any special authorization forms that you may be required to submit in order for John Hancock to obtain the necessary information regarding your claim.

It's important to start a claim as soon as you require long-term care assistance.

Starting or managing your claim online has never been easier at ltc.customer.johnhancock.com.

Reimbursement does not begin until the Elimination Period* is met

Most people will not begin receiving reimbursement checks immediately upon starting a claim. There are usually some expenses for which the claimant is responsible, possibly for several months.

What is an Elimination Period? To help distinguish acute care from true long-term care needs, most long-term care insurance products contain an Elimination Period. Similar to a deductible on auto or home insurance, you will not be eligible for reimbursement until you receive and pay for care for a certain number of days and/or dollars after you meet the benefit eligibility criteria.

The requirements of the Elimination Period (e.g., length, dollars spent, etc.) vary widely based on the type of product you have and the options you selected at the time of purchase. There may even be some types of services that will be reimbursed during this Elimination Period. We recommend that you review this section of your policy closely to understand the specifics of your coverage.

Submit invoices for all long-term care services received as soon as your benefit eligibility is approved. Services covered by Medicare may count toward your Elimination Period.

*Some products may refer to the Elimination Period as a Qualification Period or Waiting Period.

Save copies of all long-term care service invoices

Most coverage follows a Reimbursement Model – meaning, you incur and pay for certain long-term care expenses and then you are reimbursed for the actual charges (within coverage limits defined in your policy). As a result, you will need to provide documentation of the charges that are incurred and paid after the services have been rendered. Documentation typically refers to a bill from your provider that outlines each date of service, the type of service provided, and the charge for the service.

Collect all documentation, even while you are awaiting your benefit eligibility certification. As soon as you receive approval, gather all your bills for long-term care services received to date and submit them to John Hancock for processing. This will ensure that you receive appropriate credit toward your Elimination Period as quickly as possible. Continue to submit bills regularly for credit/reimbursement. Invoices must be submitted every 30 days to avoid claim closure due to inactivity.

Facility Bills: Many facilities bill in advance. While facility bills may be submitted in advance, payment will not be released until the end of the month after services have been rendered for the month.

Home Health Agency Bills: Daily care charges including the type of care provided, duration, and charge details must be itemized on invoices submitted for reimbursement. If you employ an Independent Care Provider rather than an agency, John Hancock's CareGiver mobile app is available for electronic care sessions submissions. Alternatively, you can use the Independent Care Provider Service Bill which can be uploaded and submitted online.

Medicare Charges: If your policy requires that you incur expense to meet your Elimination Period, you may be able to receive credit for covered services that are paid by Medicare. You will need to provide copies of the Medicare UB04 forms and submit those for processing. The UB04 form is a document your provider uses to submit charges to Medicare. You may not always receive this documentation, so let your provider know right away that you will need copies of the UB04 statements. A Medicare Explanation of Benefit does not contain the detail needed to apply credit to your Elimination Period.

Submitting itemized invoices online is a convenient way to ensure that you receive credit towards your Elimination Period and reimbursement of eligible long-term care expenses once your Elimination Period is met.

Allowing a family member to manage the claim

Many claimants prefer to assign a family member or advisor as the primary claim representative. In order for this person to assume full responsibility for the claim (filling out and signing forms, changing payment method, etc.), he or she will need to have financial power of attorney/guardianship (or the equivalent in your state). This does not include a health care power of attorney or health care proxy. John Hancock will need to receive HIPAA authorization from the insured or power of attorney/guardian in order to discuss coverage or claim details with someone other than the insured.

It is important to include all pages of this legal document for review. POAs may submit their legal representation online as a first step to initiating a claim.

Not all facility types are covered at the same level

Many policies make a distinction between a nursing facility, an assisted living facility, and an independent living facility. This can be especially confusing if your facility operates with multiple levels of care (i.e., a facility that has separate units for independent living and assisted living). Be sure to clarify with your provider the section in which you reside — it may change the level of reimbursement you receive. For example, your policy may cover nursing facility care and home health care, but since an Independent Living Facility (ILF) is not defined as a nursing facility, care at an ILF may only be covered for home health service/limits.

You may confirm your coverage for the level of care you are receiving by viewing your benefits online 24/7.

Long-term care insurance is underwritten by John Hancock Life Insurance Company (U.S.A.), Boston, MA 02116
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LTC-7156 6/21 MLINY052121275-1