Lincoln Financial Group®

Care Provider Statement

The Lincoln National Life Insurance Company ("Lincoln")
Lincoln Life & Annuity Company of New York ("Lincoln")
First Penn-Pacific Life Insurance Company ("Lincoln")

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PO Box 21008, Greensboro, NC 27420-1008

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This form should be completed by the facility, agency or individual providing care services for the Insured. If there are multiple providers, we need a separate form for each.

Step 1 - Guidance

Enter the policy or certificate number.

Enter any other relevant policy or certificate numbers separated by commas.

Step 1 - Insured Information

Policy Number:

First Name:

Last Name:

Date of Birth: / /

Step 2 - Guidance

Indicate Facility/Agency provider information in this section and proceed to step 4.

Individual caregivers, proceed to step 3.

Provide a copy of the license, which is a requirement to process this claim.

Step 2 - Facility/Agency Information

Corporate Name:

Doing Business as:

Mailing Address:

City: **State:** **Zip Code:**

Phone Number: - - **Mobile Number:** - -

Email Address:

License Number:

Step 3 - Guidance

Complete independent care provider information in this section.

Include a copy of your license or certification as an independent care provider.

Step 3 - Independent Care Provider Information

First Name:

Last Name:

Mailing Address:

City: **State:** **Zip Code:**

Phone Number: - -

Email Address:

Are you related to the Insured in any way? ☐ **Yes** ☐ **No**

If Yes, indicate the relationship:

Step 4 - Guidance

Indicate other insurance coverage in the space provided.

Step 4 - Other Insurance Coverage

Is any portion of the care paid by additional insurance coverage?
(i.e. Medicare, Medicaid, other government program, other Long-term Care, etc.)

If applicable, provide additional details below, including policy number(s) and/or name of insurance company.

Step 5 - Guidance

Date Care Began represents the facility admission date or the date in-home care services began.

Date Care Ended represents the facility discharge date or the date in-home care services ended.

Primary Diagnosis is the reason care began.

Itemized billing statements are required to process the claim.

Step 5 - Patient Care Information

Date Care Began: / / **Date Care Ended:** / /

Hours Per Day: **# Days Per Week:**

Primary Diagnosis:

Additional Diagnosis:

Physician recommending Care:

First Name:

Last Name:

Step 6 - Guidance

Review each Activity of Daily Living (ADL) and indicate the level of care you are providing to the insured.

A copy of the service plan/ plan of care and initial patient assessment is required to process the claim. Please submit with this completed form.

Step 6 - Patient Care Information

Indicate the level of care being provided.

	0 Independent (with/without assisted device)	1 Supervision Only	2 Standby assistance of another person	3 Hands-On assistance of another person	4 Completely Dependent
Bathing	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Eating/ Feeding	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐

Provide additional details:

Step 7 - Guidance

If testing such as a Mini Mental State Exam (MMSE) or a neuropsychological evaluation has been completed, include a copy with the claim submission.

Failure to include this may result in a delay in processing the claim.

Step 7 - Cognitive Impairment

Is a cognitive deficit present? ☐ **Yes** ☐ **No**

☐ **Needs cueing to complete most tasks.**

☐ **Allowed to leave the facility/home unattended.**

☐ **Must not leave the facility/home unattended.**

Does the Insured live alone? ☐ **Yes** ☐ **No**

If No, indicate who lives in the home, their relationship to the Insured, and any care they are providing.

Does the Insured exhibit any behaviors that are of concern? ☐ **Yes** ☐ **No**

If Yes, please provide details:

Step 8 - Fraud Warnings

Read all pertinent fraud warnings on pages 4 and 5.

Sign this form to affirm that you have read the fraud warning and that information provided on this Care Provider Statement form is complete and accurate. Signature is required for all states.

Step 8 - Certify and Sign This Care Provider Statement

Fraud Warning for 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.

NOTE: There are Fraud Warnings **above** and in the **following Fraud Warning section**.

By signing below, I acknowledge that I have read all FRAUD WARNINGS pertaining to my state.

(Signature is required for all states.)

_____ **Date:** ____ / ____ / ____

Signature of Care Provider

Print Name of Care Provider

Title of Care Provider

Fraud Warnings

Warning – Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files a statement of claim containing any false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material to the claim, commits a fraudulent insurance act, which may be a crime, and in certain states a felony. Penalties may include imprisonment, fines, denial of insurance and civil damages.

These states require the following fraud warnings:

California (For your protection, California law requires this to appear.) – 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.

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.

Kentucky – 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.

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, defrauds or deceives 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 N.H. Rev. Stat. Ann. Subsection 638:20.

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

Pennsylvania – 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.

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 with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, 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.