Guide to Service Provider Payment - Independent

We will only pay invoices for approved providers. Charges are not reimbursable if services were provided from an unapproved provider. To initiate payment to your service provider(s), follow these steps:

1. Complete

- ☐ Complete the Independent Care Provider Monthly Invoice.
- ☐ Submit proof of service.
  - All bills must be itemized and typed, and include your name and the name of the provider on the invoice.
  - Bills must include service dates and types, and fees charged per day or visit.
  - If another insurance carrier or government agency paid the charges, please submit a copy of their Explanation of Benefits statement.
- ☐ The Monthly Invoice Log, itemized bills and other insurance Explanation of Benefits statements may be considered proof for the satisfaction of the waiting period, elimination period, or deductible period, according to your coverage.
- ☐ Please do not submit invoices until after you've received service, even if you've prepaid. We do not accept invoices until after services have been received.
- ☐ Submit proof of payment (cancelled checks, bank statements, copies of money orders, cashier's check, payroll journals, pay stubs with caregiver's name, etc.).

2. Return

Submit all forms and documents to:
MetLife Long-Term Care Claims
P.O. Box 14407
Lexington, KY 40512-4633
Fax: 1-866-722-1180
Email: longtermcareclaims@metlife.com

What will happen after we receive your invoice

Payment is generally processed within ten business days after we receive complete invoices as described above.

Long Term Care

Independent care provider monthly invoice

Please complete a separate time sheet for each independent provider. Enter information for each day services were provided. Copies of cancelled checks or other proof of payment acceptable to MetLife should be attached when submitting this form

Insured's name | Social Security number | Group name/number

Provider's name

Certificate/License Type *(only for Independent care providers)*:

☐ AIDE ☐ LPN ☐ RN ☐ OT ☐ PT ☐ ST ☐ Other: _____

Month/Year (xx/xx)	Time		Description of Services Provided (Use "X")													Total Daily Hours	Total Daily Fee
	Begin	Ended	Grooming	Bathing	Personal Hygiene	Incontinence Care	Dressing Undressing	Toileting	Transfer Assistance	Medication Reminders	Grocery Shopping	Meal Prep	Feeding	Laundry House Work	Other (Specify)		
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2																	
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Fee/Hour: $ _____ Total hours: $ _____ Total amount billed: $ _____

Any person who knowingly and with intent to defraud any Insurance company or other person files a 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 Here _____ Signature of Provider _____ Date *(mm/dd/yyyy)*

Sign Here _____ Signature of Insured or Insured's representative _____ Date *(mm/dd/yyyy)*

Mail:
MetLife
Long Term Care Claims
PO Box 14407
Lexington, KY 40512-4633

Fax:
866-722-1180 (toll free)
or 859-825-6751