ALLIED PILOTS ASSOCIATION

Optional Custodial Care Benefit Plan Claim Form

Return completed form to:
Benefit Spending Accounts
P.O. Box 2968 Clinton, IA

E-mail Us: FlexHB@LuminareHealth.com
Fax Us: 866-514-8287

INSTRUCTIONS: ALL QUESTIONS MUST BE ANSWERED IN ORDER FOR YOUR CLAIM TO BE PROCESSED.
(Please file a separate FORM for each family member)
All claims must be filed within one year of date of service.

MEMBER: Complete Sections A & B. One form is required for every six months of care. Give completed form to physician.
PHYSICIAN: Complete Section C and forward to your claims office/caregiver for processing.
CARE FACILITY/CAREGIVER: Complete Section D on page 2 and forward to Luminare Health / Benefit Spending Accounts
If you have questions please contact customer service at 877-267-3359 or email us at FlexHB@LuminareHealth.com.

SECTION A

MEMBER to complete this section for all claims.

MEMBER STATEMENT

Member Name *(Last, First, Middle Initial)*	Date of Birth *(Month/Day/Year)*	Social Security Number	Gender ☐ Male ☐ Female
	_____/_____/_____		
Mailing Address (☐ *Check if new address)*	City	State	Zip Code
Spouse Name *(Last, First, Middle Initial)*	Date of Birth *(Month/Day/Year)*	Social Security Number	Gender ☐ Male ☐ Female
	_____/_____/_____		

SECTION B

MEMBER to complete this section for all claims.

MEMBER AUTHORIZATION

I hereby authorize any physician, hospital, insurance company, employer and other agencies or organizations to release any information regarding the medical history, treatment, disability or benefits payable for this claim necessary for the proper administration of the plan to which it pertains. This authorization shall extend to my spouse and eligible dependents. A photocopy of this authorization shall be as valid as the original.

Print Name of Patient _____

_____ _____/_____/_____ _____ _____/_____/_____
Member Signature Date Patient or Personal Representative's Signature (if Representative, attach copy of legal instrument) Date

SECTION C

PHYSICIAN to complete this section for this patient.

PHYSICIAN STATEMENT

Type of Care: ☐ Custodial Care ☐ Assisted Living Care ☐ In-Home Care ☐ Other (specify) _____

Name of Facility (if applicable)		Facility Telephone Number	
Facility Street Address (if other than Patient's mailing address)	City	State	Zip Code
Facility License # _____ Tax ID # _____	Date Admitted _____/_____/_____	Date Discharged _____/_____/_____	

Check all Activities of Daily Living (ADLs) Patient is unable to perform without assistance:
☐ Bathing ☐ Dressing ☐ Transferring ☐ Toileting ☐ Continence ☐ Eating

Does Patient have Severe Cognitive Impairment? (if **Yes**, attach documentation) ☐ Yes ☐ No

Is Patient expected to need assistance with ADLs or supervision for Severe Cognitive Impairment for more than 90 days? ☐ Yes ☐ No
(if **Yes**, expected period of assistance) _____

Does Patient require continual medical supervision? ☐ Yes ☐ No
(if **Yes**, expected period of medical supervision) _____

Patient Diagnosis (please be specific or attach copies of pertinent medical records, including Plan of Care)

SECTION D

CARE FACILITY or CAREGIVER to complete this section for all claims.

Type or print.

CARE FACILITY OR CAREGIVER STATEMENT

Fully describe procedure, medical services or supplies furnished for each date.

Date of Service	Place of Service* (Code 1, 2 or 3)	Services Performed	Charges
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		Total Charges	$.

Signature of Physician or Supplier	Physician's or Supplier's Contact Information	Tax ID Number
_____ Signature ____/_____/_____ Date	Name: _____ Address: _____ _____ Telephone Number: _____	

*** Place of Service Codes:** **1 (CC) Custodial Care Facility** **2 (AL) Assisted Living Facility** **3 (IH) In-Home Care**