Clear Form Data
FILLABLE FORM

Attachment F

DHS-5426E-ENG 8-08

Minnesota Department of **Human Services**

MINNESOTA Long Term Care Partnership™

Long-Term Care Partnership Updated Insurance Information

Case number: _____

Case name: _____

Worker name: _____

Worker phone number: _____

Fax number: _____

Agency name: _____

Agency address: _____

Date: _____

To: _____

The person named below has insurance that qualifies for the Long-Term Care Partnership. Therefore, he or she may designate assets that do not count for Medical Assistance for Long-Term Care. These assets also will be protected from estate recovery. The person may designate assets in an amount equal to the amount of benefits paid by his or her Long-Term Care Partnership policy.

We need updated information about this person's Long-Term Care Partnership policy. The updated information you provide will help us determine if this person qualifies for additional asset protection due to the Long-Term Care Partnership.

A signed Permission to Share Long-Term Insurance Information form is enclosed, authorizing state and county agencies to exchange health information with insurance companies in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA).

Complete the Long-Term Care Partnership Insurance Information Form about the person named below. Return the form within **10 days** to the agency contact named above:

NAME OF INSURED PERSON			DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF INSURANCE COMPANY		INSURANCE POLICY NUMBER	

Group policy information, if applicable.

INSURANCE CERTIFICATE NUMBER	NAME OF EMPLOYER OR ASSOCIATION

Insured person: _____

Case number: _____

Case name: _____

Worker name: _____

Insurance Policy Evaluation Form

Medical Assistance for Long-Term Care may not continue until you complete and return this form. **Return this form within 10 days to the agency listed on the cover letter.**

On _____ your company reported $_____ in benefits had been paid since July 1, 2006 for the insured person listed above.

Since the date of your last report, have policy benefits been exhausted?

☐ Yes – complete the following questions:

1. What amount of benefits was paid since your last report? $_____
2. What was the date of the final payment? _____

☐ No – complete the following questions:

1. What amount of benefits was paid since your last report? $_____
2. Through what date have claims been paid? _____
3. What is the approximate amount of benefits remaining? $_____

COMPLETED BY (PLEASE PRINT)	TITLE	
SIGNATURE OF INSURANCE COMPANY REPRESENTATIVE	DATE	PHONE NUMBER

This information is available in alternative formats to individuals with disabilities by calling your agency at (651) 431-2670 or (800) 657-3739. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.