Invoice for Independent Care Providers

This form should be completed by the Care Provider

Mail: [Company Name]
Attn: LTCI Claims
P.O. Box 40007, Lynchburg, VA 24506-9939
Fax: 888 557.5526
Phone: [Company Telephone Number]

[Web/email Info]

Insured's Name: [Insured's First and Last Name]

Claim Number: [XXXXXXX]

PLEASE PRINT

Care Provider's Name: _____

Care Provider's Address: _____

Care Provider's Phone No.: _____

Care Provider's Relationship to the Insured*: _____

*The contract does not generally cover care provided by family members. Please refer to the contract or contact us for information.

Tasks Instructions

To indicate what type of assistance was provided, please write an "H" for Hands-on Assistance and an "S" for Stand-by Assistance in the column for each completed task.
- **BA** (Bathing)
- **DR** (Dressing)
- **TR** (Transferring)
- **EA** (Eating/Feeding – not meal prep)
- **TO** (Toileting)
- **CO** (Continence)
- **AM** (Ambulation)

Place a "✓" in the appropriate columns if either of the following occurred:
- **CS** (Cognitive Supervision
- **HM** (Homemaker Services)

Tasks

Care Provider Invoice Instructions and Additional Questions	Date of Services	Shift Start AM/PM	Shift End AM/PM	Hours	Shift Rate	Shift Charge	BA	DR	TR	EA	TO	CO	AM	CS	HM	Other Tasks & Notes (Must report any other tasks performed, including all tasks outside of the home)
Follow this example when filling out the invoice →	9/21/24	8:30 AM	3:45 PM	7.25	$10	$72.50	H	H		S		S		✓	✓	Dr. appt, grocery shopping on 9/21
1. Use multiple lines for split shift hours.																
2. List details about tasks, such as taking the insured to Doctor appointments, grocery shopping, etc., in the "**Other Tasks & Notes**" column each day you work																
*The invoice must represent the actual shift hours you worked**																
*Note: Terms and conditions of the contract control. Not all tasks noted may be covered. For example, on-call care or other times when you are not providing services are not covered.																
				Total:		Total:										

Additional Questions

During this Work Period, the Insured:

…was hospitalized some or a portion of the time? Yes No
If "Yes" Admission Date: _____
Discharge Date: _____

…was on vacation or not home for any reason? Yes No
If "Yes" Dates Away: _____
Reason not home: _____

…had change(s) in care needs? Yes No
If "Yes" Describe: _____

State Fraud Notice: For your protection, [Resident State] law requires that we provide you with the following statement: [Required Fraud Language]

By signing below, I confirm 1) the shift hours worked, shift charges, and the contents of this invoice are true and correct; and 2) I was physically present in the Insured's home for the hours reported, except as noted above.

Signature of Care Provider: _____ Date: _____

I confirm that the information on this form is true and correct. I also acknowledge and agree that this form may be emailed by me, my authorized representative, or my care provider and that the confidentiality and security of my information may not be protected while in transmission to [Company Name].

Insured or Authorized Representative Signature: _____

Important Notes: This contract does not cover in-kind payments, bartered services, loans or other exchanges made in lieu of payment to the Care Provider. Care Provider is responsible for determining Internal Revenue Service (IRS) reporting requirements for caregiving income. California Residents: Your personal information may be subject to the CCPA. Please visit Genworth.com/ccpa to understand how we collect, use, and disclose your personal information.