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.
- All forms should include your name and the Provider's name.
- Please fill out each line with a check for services rendered, total daily hours and total daily fee.
- Please include signatures and signature date for the Insured, Spouse, or Financial Representative and Provider, as indicated at the bottom of the form.
- 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 for providers that are not related to you (cancelled checks, bank statements, copies of money orders, cashier's check, payroll journals, Zelle, PayPal, Venmo, 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.

For questions related to provider changes/additions, benefit payments, invoices, return of premiums, waiting period, direct deposit and billing questions, please contact a customer service representative at 1-888-687-0977. You can also visit www.metlife.com/ltc for direct access to important forms, documents, resources and answers to your frequently asked questions.

Long-Term Care

MetLife

Independent care provider monthly invoice

Metropolitan Life Insurance Company

Things to know before you begin

- 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.

SECTION 1: Insured information

First name	Middle name	Last 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: _____

SECTION 2: Monthly invoice log

Month/Year *(xx/xx)*	Time		Description of Services Provided *(Use "X")*													Total Daily Hours	Total Daily Fee
	Begin	End	Grooming	Bathing	Personal Hygiene	Incontinence Care	Dressing/Undressing	Toileting	Transfer Assistance	Medication Reminders	Grocery Shopping	Meal Prep	Feeding	Laundry/ House Work	Other *(Specify)*		
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
11																	
12																	
13																	
14																	
15																	
16																	
17																	

Month/Year *(xx/xx)*	Time		Description of Services Provided *(Use "X")*													Total Daily Hours	Total Daily Fee
	Begin	End	Grooming	Bathing	Personal Hygiene	Incontinence Care	Dressing/Undressing	Toileting	Transfer Assistance	Medication Reminders	Grocery Shopping	Meal Prep	Feeding	Laundry/ House Work	Other *(Specify)*		
18																	
19																	
20																	
21																	
22																	
23																	
24																	
25																	
26																	
27																	
28																	
27																	
28																	
29																	
30																	
31																	

Fee/Hour: | Total hours: | Total amount billed:

SECTION 3: Signatures

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)*

SECTION 4: How to submit this form

Mail:
MetLife
Long Term Care Claims
P.O. Box 14407
Lexington, KY 40512-4633

Fax:
866-722-1180

Email:
longtermcareclaims@metlife.com

MetLife Long-Term Care Claims

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 Metropolitan Life Insurance Company should be attached when submitting this form.

Insured name	SSN#	Group name/number	Caregiver name
Jane Doe	999-99-9999	Metlife/031254	Jane Smith

Month/Year (xx/xx)	Time		Description of Services Provided (Use "X")													Total Daily Hours	Total Daily Fee
April 2021	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)		
1	7am	3pm	X		X	X		X		X	X		X		Housework	8	$80
2	7am	3pm	X	X		X		X	X		X				Grocery Shop	8	$80
3																	
4	7am	3pm	X			X		X	X		X						$80
5																8	
6																	
7	7am	3pm		X			X		X			X			Housework	8	$80
8																	
9																	
10																	
11																	
12																	
13																	
14																	
15																	
16																	
17																	
18	4pm	12am		X		X	X				X			X		8	$80
19																	
20																	
21																	
22																	
23	10am	3pm		X		X	X		X		X	X		X		5	$50
24																	
25																	
26																	
27																	
28																	
29																	
30																	
31																	

Fee/Hour: $ 10 | Total hours: 45 | Total amount billed: $495

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 Caregiver: Jane Smith — Date *(mm/dd/yyyy)*

Sign Here — Signature of Insured or Insured's representative: Jane Doe — 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