AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

ATTN: CLAIMS DEPT., WORLDWIDE HEADQUARTERS: 1932 WYNNTON ROAD, COLUMBUS, GA 31999-7251
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522) OR VISIT OUR WEBSITE AT WWW.AFLAC.COM
TOLL FREE FAX NUMBER 1-877-44AFLAC (1-877-442-3522)

PATIENT'S CLAIM FORM - Please fully complete the top half.

FOR ASSOCIATE USE ONLY:

Check the appropriate box:
☐ Send the insured's check to the agent for delivery.
☐ Contact the associate only if additional information is needed to complete processing of this claim.

Writing #: _____ Name: _____
Address: _____

PATIENT'S INFORMATION

LAST	FIRST	MIDDLE	SEX

ADDRESS - STREET & NUMBER	

CITY	STATE/ZIP CODE

BIRTH DATE	MARITAL STATUS ___SINGLE ___MARRIED ___OTHER

RELATIONSHIP TO POLICYHOLDER _____SELF _____ SPOUSE _____CHILD _____ STEPCHILD _____OTHER:

POLICYHOLDER'S INFORMATION

LAST	FIRST	MIDDLE

ADDRESS - STREET & NUMBER	

CITY	STATE/ZIP CODE

PATIENT'S SOCIAL SECURITY NUMBER	(AREA CODE & PHONE NO.)

IS PATIENT: _____ EMPLOYED _____ PART-TIME STUDENT _____FULL-TIME STUDENT

TYPE OF CLAIM

_____ CANCER	POLICY NO(S)		
_____ INTENSIVE CARE	POLICY NO(S)		
_____ ACC/DISABILITY	POLICY NO(S)		
_____ HOSPITAL INDEMNITY	POLICY NO(S)		
_____ SPECIFIED MAJOR EVENT / OTHER	POLICY NO(S)		

BRIEFLY DESCRIBE NATURE OF ILLNESS OR HOW INJURY OCCURRED:

IF ACCIDENT, LOCATION:

DATE: TIME: AM/PM

ATTACH HOSPITAL BILL IF APPLICABLE

DO NOT WRITE ANYTHING BELOW THIS LINE EXCEPT PATIENT'S SIGNATURE. DOING SO MAY RESULT IN THE DELAY OF YOUR CLAIM.

AUTHORIZATION TO RELEASE INFORMATION
(TO BE COMPLETED BY AFLAC CLAIMS DEPARTMENT)

TO:

RE: Patient: _____
Patient Hospital #: _____
Patient's SS #: _____

TREATMENT DATE				
DISCHARGE SUMMARY				
HISTORY & PHYSICAL				
OPERATIVE REPORT				
PATHOLOGY REPORT				
PHYSICIAN'S OFFICE NOTES				
BLOOD ALCOHOL TEST				
URINE DRUG SCREEN				

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I hereby request and authorize you to furnish to AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC) or its representative any and all medical information concerning any illness or injury I may have suffered, including HIV testing, and the diagnosis and treatment of communicable diseases, ARC, AIDS, chemical dependency or psychiatric illness.

TO BE COMPLETED BY THE PATIENT

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

_____ _____
SIGNATURE OF PATIENT (IF MINOR, PARENT MUST SIGN) **DATE**
IF SIGNED IN BEHALF OF ANOTHER, RELATIONSHIP _____ **(ONLY IF PATIENT IS UNABLE TO SIGN)**

Expires six months from date written above unless indicated otherwise or revoked earlier.

PHYSICIAN'S STATEMENT

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

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TO BE COMPLETED IN FULL BY ATTENDING PHYSICIAN

PATIENT'S INFORMATION				POLICYHOLDER'S INFORMATION		
LAST	FIRST	MIDDLE	SEX	LAST	FIRST	MIDDLE
ADDRESS-STREET & NUMBER				ADDRESS - STREET & NUMBER		
CITY		STATE/ZIP CODE		CITY		STATE/ZIP CODE
BIRTH DATE	STATUS _____SINGLE _____ MARRIED _____ OTHER:			PATIENT'S RELATIONSHIP TO POLICYHOLDER: _____ SELF _____ SPOUSE _____ CHILD _____STEPCHILD ____OTHER:		PHONE
POLICY NUMBER(S):						

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DIAGNOSIS

1._____ ICD _____

2._____ ICD _____

LIST ANY CHRONIC ILLNESS OR DISEASE

1._____ ONSET DATE _____

2._____ ONSET DATE _____

3._____ ONSET DATE _____

IF INJURY, GIVE DATE AND PLACE OF INCIDENT.

_____

IF LOSS IS DUE TO ACCIDENTAL INJURY, EXPLAIN HOW ACCIDENT OCCURRED.

_____

_____

_____

IF AUTO ACCIDENT, WAS PATIENT	IS THIS ACCIDENT/ILLNESS COVERED BY WORKER'S COMPENSATION?	IS THIS ACCIDENT/ILLNESS COVERED BY MEDICAID / STATE AID?
____ DRIVER ____ PASSENGER ____ UNKNOWN	_____ YES _____ NO	_____ YES _____ NO

1. DATE SYMPTOMS FIRST OCCURRED_____ DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION_____
2. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ____ NO ____ YES (IF YES, STATE WHEN AND DESCRIBE)_____
3. REFERRING PHYSICIAN (NAME/ADDRESS_____
4. WAS PATIENT HOSPITALIZED FOR THIS CONDITION? _____ NO _____YES ***IF YES, HAVE CLAIMANT ATTACH A COPY OF THE ITEMIZED HOSPITAL BILLING WHEN SUBMITTING CLAIM FOR REVIEW .***
5. DATE PATIENT LAST EXAMINED BY YOU _____ FREQUENCY OF VISITS _____ WEEKLY _____ MONTHLY _____ OTHER
6. IS PATIENT UNABLE TO PERFORM JOB DUTIES? _____ NO _____ YES (IF YES, GIVE DATES)_____
7. WHAT SPECIFIC JOB DUTIES IS PATIENT UNABLE TO PERFORM?_____
8. IS PATIENT _____ AMBULATORY _____ BED CONFINED _____ HOUSE CONFINED _____ HOSPITAL CONFINED _____OTHER _____
9. IF RETIRED, WHICH ACTIVITIES OF DAILY LIVING (ADLs) IS PATIENT UNABLE TO PERFORM? _____

DATES OF SERVICE	PLACE OF SERVICE IN/OP	PROCEDURE DESCRIPTION	# UNITS	CODE CPT HCPCS/RVS	DIAGNOSIS CODE ICD.0	CHARGE

Date_____ SIGNED _____

Name of Attending Physician (Please Print) _____

Tax ID or Social Security Number

_____

(Street Address) (City or Town) (State) (Zip Code) (Area Code - Phone)

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_____ _____

SIGNATURE OF PATIENT (IF MINOR, PARENT MUST SIGN) DATE

(Expires six months from this date unless indicated or revoked earlier.)

If signed on behalf of another, relationship _____ (Only if patient is unable to sign)