

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 web site 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:

<input type="checkbox"/> Send the insured's check to the associate for delivery. <input type="checkbox"/> Contact the associate if additional information is needed to complete processing of this claim	Writing # _____ Name _____ Address: _____
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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	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER			PATIENT'S SOCIAL SECURITY NUMBER		(AREA CODE & PHONE NO.)
RELATIONSHIP TO POLICYHOLDER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> OTHER:				IS PATIENT: <input type="checkbox"/> EMPLOYED <input type="checkbox"/> PART-TIME STUDENT <input type="checkbox"/> FULL-TIME STUDENT		

TYPE OF CLAIM

BRIEFLY DESCRIBE NATURE OF ILLNESS OR HOW INJURY OCCURRED

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

IF ACCIDENT, LOCATION: _____

DATE: _____ TIME: _____ AM/PM

ATTACH HOSPITAL BILL IF APPLICABLE _____

Please review and sign the attached authorization. Two copies are attached: return one copy to AFLAC and keep one for your records. By returning the signed authorization with your claim, you will help us process your claim as quickly and efficiently as possible.

DO NOT WRITE ANYTHING BELOW THIS. DOING SO MAY RESULT IN THE DELAY OF YOUR CLAIM.

(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				

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of 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.

PHYSICIAN'S STATEMENT

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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 <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER: _____			PATIENT'S RELATIONSHIP TO POLICYHOLDER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER: _____				PHONE	
POLICY NUMBER(S): _____									

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DIAGNOSIS	IF INJURY, GIVE DATE AND PLACE OF INCIDENT.
1. _____ ICD _____	_____
2. _____ ICD _____	IF LOSS IS DUE TO ACCIDENTAL INJURY, EXPLAIN HOW ACCIDENT OCCURRED.
LIST ANY CHRONIC ILLNESS OR DISEASE	
1. _____ ONSET DATE _____	_____
2. _____ ONSET DATE _____	_____
3. _____ ONSET DATE _____	_____

IF AUTO ACCIDENT, WAS PATIENT <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> UNKNOWN	IS THIS ACCIDENT/ILLNESS COVERED BY WORKER'S COMPENSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THIS ACCIDENT/ILLNESS COVERED BY MEDICAID / STATE AID? <input type="checkbox"/> YES <input type="checkbox"/> NO
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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

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Date _____ Signed _____

Name of Attending Physician (Please Print) _____

Tax ID or Social Security Number _____

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

