PHYSICIAN'S TREATMENT SUMMARY

For use with Accident, Cancer and/or Sickness Only

- **Do** print this form and bring it to your provider to complete.
- **Do** complete this form for all outpatient treatment or surgeries received while confined.
- **Do** upload via SmartClaim, Claims history, fax or mail the completed form to the address at the bottom.
- **Do not** complete this form if filing for hospital benefits (Hospital benefits will require the UB04-itemized hospital bill, and can be obtained from your provider).

***Policy Number:**

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) | Telephone Number where we can reach you

*Home Address

*City | *State | *Zip Code

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy)

*Sex: ☐ Male ☐ Female *Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Treating Physician's Name	Address	Phone No.	Fax No.

Date	Procedure Code/Description	Diagnosis	Facility name/address

Was this treatment due to an accidental injury? ☐ No ☐ Yes (If Yes, complete the below questions)
Date of Injury: _____/_____/_____
Details of injury: _____

_____

Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If Yes, please include accident report)
Did this injury occur on the job? ☐ No ☐ Yes
Was death a result of this injury? ☐ No ☐ Yes (If Yes. please submit a certified death certificate and beneficiary's statement)
Was this treatment due to a sickness? ☐ No ☐ Yes (If Yes, complete the below questions)
Patient first consulted **you** for this condition on: _____/_____/_____
First date of treatment for this condition: _____/_____/_____
Was the patient treated by any other physicians for this sickness or a related condition? ☐ No ☐ Yes
Referring physician's name _____ Phone number _____
Address _____
Primary Care Physician name and address _____
If diagnosed with cancer, date of initial diagnosis: _____/_____/_____

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

PHYSICIAN SIGNATURE **TAX ID NUMBER** **DATE**

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)