Aflac cancer claim form georgia

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Payroll

HOSPITAL INTENSIVE CARE PROTECTION INSURANCE POLICY
(A10400 Series)

☐ New
☐ Conversion

Application to: American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's Name _____ (Last) (First) (MI)

DOB _____ (Month/Day/Year) Sex _____ SSN _____ - _____ - _____

Are you applying for Dependent Child(ren) coverage? ☐ Yes ☐ No
If yes, Dependent Child(ren) must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ (Last) (First) (MI) DOB _____ (Month/Day/Year) Sex _____

Address _____ (Street or Post Office Box) (Apt. No.)

City _____ State _____ ZIP _____

Home Telephone ( ) _____

Employee's Name _____ (if other than Proposed Insured) Relationship _____

Payroll Account Name _____ Payroll Account No. _____ (Optional)

Is this insurance intended to replace any other hospital intensive care insurance now in force? If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.	☐ Yes ☐ No
Does anyone to be covered have any other hospital intensive care coverage with Aflac? If yes, this must be a conversion of that coverage. If yes, give current policy number and see Item 18. Policy Number: _____	☐ Yes ☐ No
Does anyone to be covered have a Specified Health Event policy with Aflac that contains intensive care benefits? If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling the Aflac policy with intensive care benefits.	☐ Yes ☐ No

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	☐ Individual	☐ Named Insured/ Spouse Only	☐ One-Parent Family	☐ Two-Parent Family
☐ Plan 1: (Policy Series A10400) ☐ Plan 2: (Policy Series A10401H)				☐ Pre-Tax or ☐ After-Tax

Aflac
aflac.com
We've got you under our wing.

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA | MEDICARE | MEDICAID | TRICARE (CHAMPUS) | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER | PICA

1. MEDICARE / MEDICAID / TRICARE (CHAMPUS) / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE SEX
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No., Street)
CITY / STATE
8. PATIENT STATUS
CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)
ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous)
a. INSURED'S DATE OF BIRTH SEX
b. OTHER INSURED'S DATE OF BIRTH SEX
b. AUTO ACCIDENT? PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT?
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH #

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org
APPROVED OMB-0938-0999 FORM CMS- 1500 (08/05)

Aflac™

Cancer Screening Wellness Benefit Claim Form

Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures or call 1-800-99-AFLAC (1-800-992-3522) for a Wellness Form specifically tailored for your policy.

Please use black or blue ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail the completed form to the Aflac address shown below.

Policyholder Information
Policyholder's First Name: Middle Initial: Policyholder's Last Name:
Policyholder's Birth Date: M M D D Y Y Y Y ZIP of mailing address:
Policy Number

Insured Information
First Name: Middle Initial: Last Name:
Relationship: Primary Policyholder / Spouse / Dependent Child
Sex: Male / Female
Patient's Birth Date: M M D D Y Y Y Y

Wellness Exam
Treatment Date: M M D D Y Y Y Y
- Colonoscopy
- Virtual colonoscopy
- Pap smear - ThinPrep
- Pap smear
- Hemoccult stool specimen
- CEA (blood test for colon cancer)
- CA 125 (blood test for ovarian cancer)
- Mammogram
- Flexible sigmoidoscopy
- Thermography
- Chest X-ray
- PSA (blood test for prostate cancer)
- Breast ultrasound/Breast sonogram
- Biopsy

Pap Smear Date: M M D D Y Y Y Y
Mammogram Date: M M D D Y Y Y Y
Provide Actual Cost for Mammogram:

Physician Information
Phone Number: ( ) -
Name:
Street Address:
City: State: ZIP:

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.

I certify that the information provided is true and correct:

POLICYHOLDER'S SIGNATURE **DATE**

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7251
1-800-99-AFLAC (1-800-992-3522) • aflac.com • 1-800-SI-AFLAC (1-800-742-3522) en español

20615EPCA

How to file a cancer claim with aflac. How do i file a cancer claim with aflac. Aflac cancer insurance claim form. Aflac cancer form claim.

File a Wellness Benefit Claim Aflac is here to help. If you are filing for a health screening on your Hospital Indemnity, Accident, or Critical Illness plan for Coronavirus (COVID-19) testing, select Biometric Screening as your exam. Claims are subject to policy terms and conditions. File a Wellness Benefit Claim Online Simply select "File Online" below and follow the instructions. File Online File a Wellness Benefit via Fax or Mail Please fully complete the claim form for the Wellness Benefit. Please date and sign all required forms where indicated. Forms: Wellness Claim Form File an Accident Claim File an Accident Claim Online Simply select "File Online" below and follow the instructions. File Online File an Accident Claim via Fax or Mail Please provide a date and complete description of your accident. You can provide this information in the designated space on the claim form. If the accident resulted from the use of a motor vehicle(s), a copy of the police or accident report is required. If your injury occurred on the job, a first report of injury filed with your employer must be attached to the completed claim form. If you were first treated in an emergency room, a copy of the hospital discharge papers is required to verify the first date of treatment, diagnosis, and procedure. Please include all dates of treatment and charges incurred due to the accident. Please date and sign all required forms where indicated. Forms: Group Accident Claim Form File a BenExtend Claim Group BenExtend Claims A BenExtend claim requires supporting documentation for review of benefits such as an itemized bill if there was a hospital stay, itemized bill from physician's office, surgical report if surgery took place, Xray/Diagnostic Test reports with dates and charges if applicable, accident report if applicable, and a signed and dated Authorization for Disclosure of Health Information (HIPAA form). Please date and sign all required forms where indicated. Forms: Group BenExtendSM Claims File a Cancer Claim File a Cancer Claim via Fax or Mail Please submit the pathology report used in the diagnosis of a malignant cancer, the claimant's birth certificate, and any itemized medical bills with the diagnosis and procedure codes, as well as a signed and dated Authorization for Disclosure of Health Information (HIPAA form). Also, if you are filing during the first year of your coverage effective date, we'll need you to provide the information requested on the Pre-Existing Investigation Statement. Please date and sign all required forms where indicated. Forms: Group Cancer Claims File a Critical Illness Claim File a Critical Illness Claim Online *Before filing a critical illness claim online, please ask your physician to complete and return the Physician's Statement Form* If you have already had your physician complete and return this form, simply select "File Online" below and follow the instructions. Physician's Statement Form File Online File a Critical Illness Claim via Fax or Mail For critical illness claims, we need information from you and your attending physician. Please provide all information requested on the Insured's Statement portion of the claim form. The Attending Physician’s statement portion of the critical illness claim form is to be completed by the physician who first diagnosed your condition. Please submit required medical documentation for the specific covered critical illness, the claimant's birth certificate, a list of the names of all doctors and hospitals in the appropriate section, as well as a signed and dated Authorization for Disclosure of Health Information (HIPAA form). Also, if you are filing during the first year of your coverage effective date, we'll need you to provide the information requested on the Pre-Existing Investigation Statement. Please date and sign all required forms where indicated. Forms: Group Critical Illness Claims File a Dental Claim File a Dental Claim via Fax or Mail Please complete the Patient section, Boxes 8–18, as well as the Policyholder/Employee section (excluding Boxes 31–38 and 40.) Your dentist should complete the Billing Dentist section, Boxes 42–66 (excluding Box 53). Please date and sign all required forms where

indicated. Forms: Group Dental Claims File a Disability Claim File a disability via Fax or Mail For disability claims, we will need information from you, from your employer, and from your attending physician. Please provide all the information requested in Part A of the initial claim form. Your employer is responsible for providing the information in Part B, and your attending physician is responsible for providing the information in Part C. In addition, please read and then sign the Authorization for Disclosure of Health Information (HIPAA form) included in Part A, as well as the separate Authorization for Disclosure of Health Information (HIPAA form). Please date and sign all required forms where indicated. Forms: Disability Claim Form Continuing Disability Claim Form If this is a Disability Product with your policy number beginning with AFL, please use the form below. Short Term Disability/Long Term Disability Claim Form File a Hospital Claim File a Hospital Claim Online Simply select "File Online" below and follow the instructions. File Online File a Hospital via Fax or Mail A hospital indemnity claim requires supporting documentation for review of benefits, itemized bills showing medical treatment dates and diagnosed conditions, hospital admission and discharge papers for inpatient hospital admission and confinement benefits, pharmacy receipts for prescription drug reimbursement, and a signed and dated Authorization for Disclosure of Health Information (HIPAA form). Also, if you are filing during the first year of your coverage effective date, we'll need you to provide the information requested on the Pre-Existing Investigation Statement. Please date and sign all required forms where indicated. Forms: Hospital Indemnity Claim Form File a Group Life Insurance or Accidental-Death and Dismemberment Insurance Rider Claim Group Life Insurance or Accidental-Death and Dismemberment Insurance Rider Claims Please provide a certified copy of the deceased person's birth certificate and death certificate. If the cause of death is an injury or accident, include a copy of any related police report and/or newspaper articles. Please date and sign all required forms where indicated. Forms: If your certificate number issued to you is in a numerical value, Example: 1234567891, please only use the two forms below. Accelerated Death Benefit Claim Form Beneficiary's Statement for Death Claim Form If this is an Employer Sponsored Term Life Product with your policy number beginning with AFL, please use the forms below. Death Benefit Proceeds Claim Form Life Waiver of Premium Claim Form File a Universal Life Insurance Claim underwritten by Trustmark Insurance Company Claim Universal Life Insurance underwritten by Trustmark Insurance Company To file a claim, simply select the appropriate claim form for your specific product and mail or fax it to us at the address on the form. 1. Download the form. 2. Fill it out. 3. Send it in to: PO Box 60676, Worcester, MA 01606 Claim Forms Death Benefit Claim Form Accelerated Death Benefit Claim Form Waiver of Premium Claim Form-Initial Waiver of Premium Claim Form-Continuance Waiver of Premium Claim Form-Permanent Long Term Care/Home Health Care Benefit Claim Form Service Forms Change Your Name Change Your Beneficiary Secondary Addressee Automatic Bank Draft/Electronic Funds Transfer Request Loan Request Life Surrender Request Partial Life Surrender Change of Ownership Change of Age (Birthdate) Removal of Riders New York Domestic Violence Notice (For Life Insurance Policyholders) Lost Check Agreement Authorization to Obtain Information Form Authorization to Obtain Information Form Please date and sign all required forms where indicated. Forms: Authorization to Obtain Information Form Direct Deposit of Claims Payment Form Direct Deposit of Claims Payment Form To have your claims payment direct deposited, please download and fill out this Electronic Funds Transaction Authorization form. This form may be used on all product claims except Group Term Life, Group Whole Life and AD&D claims. Once complete, please return it to: Continental American Insurance Company Mail: Post Office Box 84075, Columbus, GA 31993 Phone: 800.433.3036 Fax: 866.849.2970 Email: groupclaimfiling@aflac.com Forms: For Direct Deposit of Claims Payment Waiver of Premium Form Waiver of Premium Form Please date and sign all required forms where indicated. Forms: Initial Waiver of Premium Form Waiver of Premium Form File a Wellness Benefit Claim File a Wellness Benefit Via Fax or Mail Please fully complete the claim form for the Wellness Benefit. Please date and sign all required forms where indicated. Forms: Accident Wellness Claim Form Critical Illness Wellness Claim Form File an Accident Claim File an Accident via Fax or Mail Please provide a date and complete description of your accident. You can provide this information in the designated space on the claim form. If the accident resulted from the use of a motor vehicle(s), a copy of the police or accident report is required. If your injury occurred on the job, a first report of injury filed with your employer must be attached to the completed claim form. If you were first treated in an emergency room, a copy of the hospital discharge papers is required to verify the first date of treatment, diagnosis, and procedure. Please include all dates of treatment and charges incurred due to the accident. Please date and sign all required forms where indicated. Forms: Accident Claim Form File a Critical Illness Claim File a Critical Illness via Fax or Mail For critical illness claims, we need information from you and your attending physician. Please provide all information requested on the Insured's Statement portion of the claim form. The Attending Physician's statement portion of the critical illness claim form is to be completed by the physician who first diagnosed your condition. Please submit required medical documentation for the specific covered critical illness, the claimant's birth certificate, a list of the names of all doctors and hospitals in the appropriate section, as well as a signed and dated Authorization for Disclosure of Health Information (HIPAA form). Also, if you are filing during the first year of your coverage effective date, we'll need you to provide the information requested on the Forms: Critical Illness Claim Form File a Hospital Indemnity Claim File a Hospital Indemnity via Fax or Mail A hospital indemnity claim requires supporting documentation for review of benefits, itemized bills showing medical treatment dates and diagnosed conditions, hospital admission and discharge papers for inpatient hospital admission and confinement benefits, pharmacy receipts for prescription drug reimbursement, and a signed and dated Authorization for Disclosure of Health Information (HIPAA form). Also, if you are filing during the first year of your coverage effective date, we'll need you to provide the information requested on the Pre-Existing Investigation Statement. Forms: Hospitalization Claim Form File a Universal Life Insurance Claim underwritten by Trustmark Insurance Company Universal Life Insurance underwritten by Trustmark Insurance Company To file a claim, simply select the appropriate claim form for your specific product and mail or fax it to us at the address on the form. 1. Download the form. 2. Fill it out. 3. Send it in to: PO Box 60676, Worcester, MA 01606 Claim Forms NY - Death Benefit Claim Form NY - Accelerated Death Benefit Claim Form NY - Waiver of Premium Claim Form-Initial Waiver of Premium Claim Form-Continuance NY - Waiver of Premium Claim Form-Permanent NY - Convalescent Care Benefit Claim Form Service Forms Change Your Name Change Your Beneficiary Secondary Addressee Automatic Bank Draft/Electronic Funds Transfer Request Loan Request Life Surrender Request Partial Life Surrender Change of Ownership Change of Age (Birthdate) Removal of Riders New York Domestic Violence Notice (For Life Insurance Policyholders) Lost Check Agreement Authorization to Obtain Information Form Authorization to Obtain Information Form Please date and sign all required forms where indicated. Forms: Authorization to Obtain Information Form