

CANCER CLAIM FORM – PHYSICIAN'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

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.

Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

SECTION B: PHYSICIAN'S STATEMENT Please answer each question COMPLETELY.

PHYSICIAN'S NAME	PHONE NUMBER ()	FAX NUMBER ()
MAILING ADDRESS	CITY	STATE ZIP

1. Has patient been diagnosed with cancer? Yes No

Type of cancer: _____ ICD code: _____

2. Date of initial diagnosis: ____/____/____

Please provide the patient with a copy of the pathology report that diagnosed cancer, as it is required for all initial claims.

3. Patient first consulted you for this condition on: ____/____/____

4. Was the patient referred to you by another physician? Yes No

If yes, physician's name: _____

Referring physician's address: _____ Phone number: _____

Hospitalization Information:

Was patient hospitalized as a result of this diagnosis? Yes No If additional dates exist, please attach a copy of itemized billing.

Admission Date	Discharge Date	Admitting Diagnosis/ICD Code	Hospital Name (Please include city and state.)

(PHYSICIAN'S STATEMENT CONTINUED ON PAGE 3)

PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

American Family Life Assurance Company of Columbus (Aflac)
 Attention: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
 For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at aflac.com
 Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

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Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

Surgery Information: Where was the surgery performed? Office Surgical Center Outpatient Hospital Inpatient Hospital

Name of facility: _____

Did patient undergo surgery for this condition? Yes No If additional dates exist, please attach a copy of itemized billing.

Date of Service	Diagnosis/ICD Code	Surgery/CPT Code	Description of Surgery	Facility Name	Charges

Chemotherapy Information

Has patient received chemotherapy? Yes No If additional dates exist, please attach a copy of itemized billing.

Date	HCPCS/CPT Code	Drug Name and Method of Administration	Drug Charge

Radiation Therapy Information

Has patient received radiation therapy? Yes No If additional dates exist, please attach a copy of itemized billing.

Date	CPT Code	Description	Charge

PHYSICIAN'S SIGNATURE

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