CANCER CLAIM FORM

Thank you for trusting Aflac New York with your Cancer needs.

- **If you are interested in filing your claim online or uploading documentation on an existing claim, register using aflac.com/smartclaim.**

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy.**

***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

☐ *Check box if this is a permanent address change.*

Patient Information:

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

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Cancer Checklist

- Is this the initial claim for this cancer diagnosis? ☐ No ☐ Yes (If yes, please submit the initial pathology report or exam that diagnosed cancer.)
- Please be sure to include the following information along with this claim form: positive Pathology Report and itemized bills from facility including diagnosis and/or procedure codes and charge amounts (Itemized bills may include but are not limited to the following: UB04 from your provider, HCFA1500 from your provider, etc.)
- Has the patient been diagnosed with cancer? ☐ No ☐ Yes (If yes, please submit the initial pathology report or exam that diagnosed cancer.)
- Type of cancer: _____
- Date of initial diagnosis: _____/_____/_____
- First date of treatment for this diagnosis: _____/_____/_____

American Family Life Assurance Company of New York
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255
For information or to check claim status, visit aflac.com or call 1-800-366-3436
Claims may be faxed to 1-877-844-0201

If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

*Policy Number:

Policyholder Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

Patient Information:

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

- Was the patient confined to the hospital as a result of this diagnosis? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04 from your provider, or HCFA 1500 from your provider.)
  Hospital name _____
  City _____ State _____
- Please provide the name, address and phone number of the patient's primary treating physician.
  Name: _____ Phone Number: _____
  Address: _____
- Was the patient treated by any other physicians? ☐ No ☐ Yes
  If yes, physician's name(s): _____
  Phone Number(s): _____
  Address: _____
- Did the patient undergo surgery for this condition? ☐ No ☐ Yes (If yes, please submit a copy of the operative report, surgeon's bill and anesthesia bill to include charges.)
  Where was the surgery performed? ☐ Office ☐ Surgical Center ☐ Outpatient Hospital ☐ Inpatient Hospital
  Name of facility: _____ Address: _____
- Has the patient received chemotherapy? ☐ No ☐ Yes (If yes, please submit a copy of itemized billing.)
  Name of facility where chemotherapy was received: _____
  Address: _____
- Has the patient received oral chemotherapy? ☐ No ☐ Yes (If yes, please submit pharmaceutical statements.)
- Has the patient received topical chemotherapy (Treatment with anticancer drugs in a lotion or cream applied to the skin)?
  ☐ No ☐ Yes (If yes, please submit pharmaceutical statements.)
- Has the patient received radiation therapy? ☐ No ☐ Yes (If yes, please submit a copy of itemized billing.)
  Name of facility where radiation was received: _____
  Address: _____
- Transportation/Lodging Information: To be completed if you are filing a claim for transportation or lodging: (please submit the hotel receipts and mileage information) *For additional information, please refer to your policy language.

Date	To/From	Round-Trip Mileage	Type of Treatment

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

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