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 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.

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

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 1-877-44-AFLAC (1-877-442-3522)