LONG TERM CARE CLAIM FORM

Thank you for trusting Aflac with your Long Term Care needs.

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

*Social Security Number

Long Term Care Checklist

In addition to this form, we must receive a bill from your provider verifying services were rendered.

Please provide the name, address, and phone number of the patient's primary treating physician.

Name: _____ Phone Number: _____

Address: _____

Is the patient deceased? ☐ No ☐ Yes (If yes, date of death: ____/____/____)

***If yes, please submit a copy of the death certificate and legal documents verifying the person authorized to handle the affairs of the deceased.**

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.

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

LONG TERM CARE CLAIM FORM - ADMITTING PHYSICIAN'S STATEMENT

***Policy Number:**

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

Patient Information:

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

Physician Information:

*Phone Number | *Fax Number

*Physician's Name

*Address

*City | State | Zip Code

Admitting Diagnosis	ICD Code	Onset Date	First Consult Date
1.			
2.			

Other Diagnoses Treated in the Past Two Years	Date
1.	
2.	

- Is the patient deceased? ☐ No ☐ Yes (If yes, date of death: ____/____/____)
- Check ADLs patient is unable to perform without assistance:

☐ Continence	☐ Transferring	☐ Dressing	☐ Toileting	☐ Eating	☐ Other

- Is patient expected to need assistance with ADLs or supervision for cognitive impairment for more than 90 days?
  ☐ No ☐ Yes (If yes, expected period of illness: _____)
- Does patient require continual medical supervision? ☐ No ☐ Yes (If no, Explain: _____)
- Was the patient treated for the primary diagnosis by another physician? ☐ No ☐ Yes
  - If yes, physician's name: _____
  - Treating physician's address: _____ Phone Number: _____

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PHYSICIAN'S SIGNATURE | **NAME OF ATTENDING PHYSICIAN (PLEASE PRINT)** | **DATE**

American Family Life Assurance Company of Columbus (Aflac)
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LONG TERM CARE CLAIM FORM - NURSING DIRECTOR'S STATEMENT

***Policy Number:**

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

Patient Information:

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

Institution Information:

*Phone Number | *Fax Number

*Name of the Institution

*Address

*City | *State | *Zip Code

- Date of admission to this facility: ____/____/____ Date of discharge from this facility: ____/____/____
- Admitting diagnosis: _____ Any additional diagnoses: _____
- Check ADLs patient is unable to perform without assistance:
  ☐ Continence ☐ Dressing ☐ Transferring ☐ Toileting ☐ Eating ☐ Other
- Is patient expected to need assistance with ADLs or supervision for cognitive impairment for more than 90 days?
  ☐ No ☐ Yes (If yes, expected period of illness: _____)
- Does this require continual medical supervision? ☐ No ☐ Yes (If no, explain: _____)
- Was any portion of this confinement covered by Medicare? ☐ No ☐ Yes (If yes, list dates and attach billing or Explanation of Medicare Benefits: _____)
- Is this patient a Medicaid recipient? ☐ No ☐ Yes (If yes, list eligibility dates: _____)
- Which type of care are you licensed to provide?
  ☐ Skilled ☐ Intermediate ☐ Custodial ☐ Personal ☐ Assisted Living ☐ Residential ☐ Respite ☐ Other
- What is the facility's primary license? _____
- Facility License Number: _____
- Indicate type of care received and dates of confinement:

☐ **Skilled Nursing**	_____ **to** _____		☐ **Residential Facility**	_____ **to** _____	
☐ **Intermediate Nursing**	_____ **to** _____		☐ **Domiciliary Care**	_____ **to** _____	
☐ **Custodial Care**	_____ **to** _____		☐ **Retirement Home**	_____ **to** _____	
☐ **Assisted Living**	_____ **to** _____		☐ **Sheltered Care**	_____ **to** _____	
☐ **Personal Care**	_____ **to** _____		☐ **Respite**	_____ **to** _____	
☐ **Alzheimer's Unit**	_____ **to** _____		☐ **Other**	_____ **to** _____	

- Were there any out of facility days during this period of care? ☐ No ☐ Yes (If yes, were they ☐ hospital days or ☐ bed hold days)
- Was patient confined to the hospital during this period of care? ☐ No ☐ Yes (If yes, list dates _____)
- Was patient confined to another facility or hospital prior to your services? ☐ No ☐ Yes (If yes, give name and address of facility and dates of confinement:
  Name and address of facility: _____ Date: _____
  Name and address of facility: _____ Date: _____

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NURSING DIRECTOR'S SIGNATURE | **DATE** | **TAX ID NUMBER**

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