

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.

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Long Term Care Checklist In addition to this form, we must receive a bill from your provider verifying services were rendered.																																		
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Please provide the name, address, and phone number of the patient's primary treating physician.																																		
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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)

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PHYSICIAN'S SIGNATURE NAME OF ATTENDING PHYSICIAN (PLEASE PRINT) DATE												IG F	HYS	ICIA	N (P	<u></u>		DAT	E											

LONG TERM CARE CLAIM FORM - ADMITTING PHYSICIAN'S STATEMENT

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 □ 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:)																				
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LONG TERM CARE CLAIM FORM - NURSING DIRECTOR'S STATEMENT

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