VISION CLAIM FORM

FILING CLAIM FOR (check all that apply)**:**

☐ Disease/Disorder of the Eye ☐ Impairment due to Accident ☐ Hospitalization ☐ Deceased - Date Deceased:____/____/____

Vision Policy Number	Accident Policy Number	Hospital Indemnity Policy Number

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

INSTRUCTIONS:

☐ Complete Section A: Policyholder/Patient Information and sign your claim form.

☐ Have the treating physician complete Section B: Physician's Statement and sign the claim form.

☐ If you are filing for disability, please complete the Initial Disability Claim Form (S00224) as well. Forms are available on our web site at aflac.com.

☐ Submit all bills related to this claim, such as hospital, surgery, etc. All bills should include the diagnosis, services rendered, and actual charges for the service.

☐ If hospitalized and/or confined to an intensive care unit, please send a copy of your hospital bill showing charges and the number of days you were confined. If confined to an intensive care unit/step-down unit, the bill must specify the number of days you spent in the intensive care unit/step-down unit.

☐ The items above can be obtained directly from your healthcare provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (non-hospital bill).

Be sure to include your policy number(s) on all documents.

Policyholder Information
(Please print.)

First Name _____ Initial ____ Last Name _____

Mailing Address _____

City _____ State _____ ZIP _____

Check box if this is a new permanent address: ☐

Patient Information
(Please print.)

Social Security Number _____ Phone Number _____

First Name _____ Initial ____ Last Name _____

Relationship:
☐ Primary Policyholder ☐ Spouse

Sex:
☐ Male ☐ Female

Patient Birth Date: _____

☐ Dependent Child ☐ Check here if dependant child is a full-time student (if over the age 19, please provide school name and contact information).

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.

_____ _____ _____

CLAIMANT SIGNATURE **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** **DATE**

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)

VISION CLAIM FORM – PHYSICIAN'S STATEMENT

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

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Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Birth Date: _____ Patient Is: ☐ Male ☐ Female

Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent -- Check here if dependent is full-time student ☐

SECTION B: PHYSICIAN'S STATEMENT (Continued on Page 3)

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

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

If yes, physician's name: _____

Referring physician's address: _____ Phone number: _____

2. Diagnosis: ☐ Macular Degeneration ☐ Retinal Detachment ☐ Glaucoma (excluding preglaucoma and/or borderline glaucoma)
☐ Proliferative Diabetic Retinopathy ☐ Retinitis Pigmentosa

3. ICD-9 Diagnosis Code: _____

If not listed above, please indicate diagnosis here: _____

VISION CLAIM FORM – PHYSICIAN'S STATEMENT

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Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Birth Date: _____ Patient Is: ☐ Male ☐ Female

Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent - Check here if dependent is full-time student ☐

SECTION B: PHYSICIAN'S STATEMENT (Continued from Page 2)

4. **Permanent Visual Impairment -** Please indicate level of visual impairment below (check one):

☐ Left ☐ Right	☐ **LEVEL 1 - SEVERE VISUAL IMPAIRMENT:** Maximal visual acuity, after correction, of 20/200 or less, or a total diameter of the visual field in that eye of 20 degrees or less.
☐ Left ☐ Right	☐ **LEVEL 2 - PROFOUND VISUAL IMPAIRMENT:** Maximal visual acuity, after correction, of 20/500 or less, or a total diameter of the visual field in that eye of 10 degrees or less.
☐ Left ☐ Right	☐ **LEVEL 3 - NEAR-TOTAL VISUAL IMPAIRMENT:** Maximal visual acuity, after correction, of less than 20/1000, or a total diameter of the visual field in that eye of 5 degrees or less.
☐ Left ☐ Right	☐ **LEVEL 4 - TOTAL VISUAL IMPAIRMENT:** Complete loss of vision with no remaining perception of light, or loss of the natural eye.

5. Symptoms first occurred on: _____/_____/_____ Date of initial diagnosis: _____/_____/_____

6. Patient first consulted you for this condition on: _____/_____/_____

7. Did patient undergo surgery for this diagnosis? ☐ Yes ☐ No

Date	CPT/HCPCS Code	Description	Eye	Charge

8. Was patient hospitalized for this diagnosis? ☐ Yes ☐ No

If yes, admission date: _____/_____/_____ Date of discharge: _____/_____/_____

Hospital Name: _____

City: _____ State: _____

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
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Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

Claims Authorization to Obtain Information

Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. **All areas of this form should be completed.**
2. **This form must be signed and dated by the claimant/patient below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased, please check here ☐**
4. **If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.**
5. **Fax this form to 1-877-442-3522 or return the form to Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999 as soon as possible to expedite the review of your claim.**

Policyholder Name:	**Policy Number(s):**	**Date of Birth:**
Policyholder Address:		
Claimant/Patient Name (if different from named policyholder listed above):		**Date of Birth:**

Name and Address of health care provider(s), company, or individual authorized to release the requested information:

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:

Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of Columbus (Aflac)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, except to the extent that:
   a. Aflac has taken action in reliance to this authorization, or
   b. Other law provides Aflac with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative ☐ **Date**

Printed name of claimant/patient, guardian or authorized representative **Relationship**