



# 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 register on Aflac.com or download the MyAflac mobile app and upload documentation.

- 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
*Date of Birth (mm/dd/yy)	Telephone Number where we can reach you		
<input type="text"/>	<input type="text"/>		
*Home Address			
<input type="text"/>			
*City	*State	*Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

**Patient Information:**

*Last Name	*First Name	*Date of Birth (mm/dd/yy)
<input type="text"/>	<input type="text"/>	<input type="text"/>
*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	*Relationship: <input type="checkbox"/> Primary Policyholder <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child	

Treating Physician's Name	Address	Phone No.	Fax No.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date	Procedure Code/Description	Diagnosis	Facility name/address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 subjects such person to criminal and civil penalties.**

PHYSICIAN SIGNATURE

TAX ID NUMBER

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)