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Aflac Long Term Care / Home Health Care Claim

For Claims Customer Service: Phone: (800) 225-3859
For Claims Submission: Fax: (508) 853-0310
Email: Claims@UAFac.com
Mail: Attn: Life Claims PO Box 60676, Worcester, MA 01606

Instructions: In order to provide prompt service to your request for Long Term Care, Home Health Care, and/or Adult Care Benefits, complete form as follows:
Section A - Statement of the Insured in its entirety
Sign and Date the Disclosure Authorization
Attending Physician's Statement to be completed by your physician

Section A - Statement of the Insured
Policy / Certificate #:
Name: DOB: SSN:
Address:
Phone #: Home Cell Work E-Mail Address:
Employer:
Date Last Worked:
Benefit(s) applied for: Long Term Care Home Health Care Adult Day Care Assisted Living
Name & Address of Agency Providing Care:
Physician Who is Certifying Care:
Doctors Consulted Other Than Certifying Physician, For Present Condition:
Name of Hospital: Date Admitted: Date Discharged:
Date of Accident / Illness: Description of Accident / Illness:
Is this a work-related injury or illness? Yes No Place of Accident:
Nature & Extent of Injury or Illness: Date of 1st Treatment:
Have you had any other medical attention in the past five (5) years? Yes No
If yes, please complete following:
Name Address Phone
Dates of Treatment

What activities of Daily Living are you currently unable to perform without assistance? (Please check all that apply)
Bathing Toileting Dressing Walking Eating Taking Medication Getting In & Out of Bed
If any checked above, please explain:
If patient is incompetent, please provide name, address, and notarized powers for Guardian, Conservator, Power of Attorney, or Trustee who is responsible for financial affairs.
Name:
Address:
*** Complete & Sign Disclosure Authorization Portion of Claim Form ***

Aflac VS.16

Dental Claim Form
American Dental Association, 1999 version 2000



CONTINENTAL AMERICAN INSURANCE COMPANY
PO BOX 84079 - COLUMBUS, GA - 31909
Toll Free: 1-866-849-0317 Fax: 1-866-849-2970

Dental Claim Form fields:
1. Dentist's pre-treatment address: Specialty (See backsheet)
2. Dentist's statement of actual services:
3. Medical Claim Prior Authorization #
4. Carrier Name: Continental American Insurance Company
5. Carrier Address: P.O. Box 8749
6. City: Columbia
7. State: SC
8. Zip: 29202
9. Patient Name (Last, First, Middle)
10. Address
11. City
12. State
13. Date of Birth (mm/dd/yyyy)
14. Certificate #
15. Sex: Male Female
16. Phone Number:
17. Zip Code
18. Relationship to Certifying Physician:
19. Employer Name:
20. Address:
21. Cert. Hold. (Emp. ID/ID#)
22. Employer Name:
23. Group #
24. Certifying Physician's name (Last, First, Middle)
25. Address:
26. Phone Number:
27. City:
28. State:
29. Zip Code:
30. Date of Birth (mm/dd/yyyy)
31. Marital Status:
32. Sex:
33. Certifying Physician's name (Last, First, Middle)
34. Address:
35. Phone Number:
36. City:
37. State:
38. Zip Code:
39. I have been informed of the treatment and associated fees...
40. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
41. Name of Billing Dental or Dental Entity:
42. Address:
43. Phone Number:
44. Provider ID #:
45. Dental Soc. Sec. or T.I.N.
46. Dental License #:
47. First visit date of current series:
48. Place of treatment:
49. Radiographs or models enclosed?
50. Is treatment for orthodontia?
51. Is treatment result of occupational illness or injury?
52. Is treatment result of auto accident?
53. Diagnosis Code Index (optional)
54. Examination and treatment plans - List teeth in order
55. Identify all missing teeth with X
56. I hereby certify that the procedures as indicated by date are in progress...
57. Address where treatment was performed

American Dental Association, 1999

CAF00IDENTAL-12v2



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PDF forms for web - aflac accident hospital indemnity/wellness/benefit/claim form Do not include receipts, statements or other documentation do not include receipts, statements or other docum Immunization - aflac group insurance immunization accident wellness benefit claim form New claim form.pdf for web - 06/01/99 - aflac file new claim form.pdf for web - 06/01/99 aflac - accident wellness benefit claim form - home aflac In accident wellness benefit claim form plus Accident wellness benefit claim form accident wellness benefit claim form failure to go Accident wellness benefit claim form instructions 06/00 health accident wellness benefit claim form In Accident wellness benefit claim form - cooper accident wellness benefit claim form failure to go Hospital indemnity wellness benefit claim form hospital indemnity wellness benefit claim form to Aflac accident wellness claim form - indian river do not include receipts, statements or other docum Aflac wellness form - indiana in 1-800-99-aflac 1-800-992-3922 (Aflac) aflac/aflac - 900-af Accident claim form - sepper farms accident claim form Aflac/Aflac was death a result of this Do not include receipts, statements, or other do not include receipts, statements, or other docum Accidental injury claim form - gallitz date of accident: _____ describe american family Aflac claims 1-877-44-aflac - aflac claim region 1-877-44-aflac (1-877-442-3922) Aflac/Aflac the system co. Sickness claim form - good address claim form Aflac/Aflac employer's disability state Accident wellness benefit claim form - fire fighters of ma accident wellness benefit claim form instructions Wellness benefit claim form - myra wellness benefit claim form submitting a wellness Aflac cancer wellness benefit claim form - alba, alaska american family health insurance company columbus/aflac Critical illness wellness benefit claim form ca001 (web 12/04 critical illness wellness benefit Do not include receipts, statements, or other do not include receipts, statements, or other docum Cancer wellness benefit claim form - proves cancer wellness benefit claim form under this pol. Accidental injury claim form - district home - good accidental injury claim form Aflac/Aflac we require copy Cancer claim form - todd peter Aflac/Aflac cancer claim form should be completed on or Aflac cancer care - aflac logo aflac cancer care cancer indemnity insurance claim Aflac quick tips for filing claims - yola aflac quick tips for filing claims accident always Do not include receipts, statements, or other do not include receipts, statements, or other docum Section 2 policy benefits - gateway insurance 17 policy benefits accident follow-up treatment be Aflac group critical illness aflac group critical illness insurance Aflac/Aflac plan In Accidental Injury claim form - start here, get there, accidental injury claim form accident policy number

Another File:
pdf forms for web - aflac - do not include receipts, statements or other documentation , immunization - aflac group insurance new claim form.pdf for web - 06/01/99 - aflac - accident wellness benefit claim form - home - accident wellness benefit claim form - accident wellness benefit claim form instructions - accident wellness benefit claim form - cooper - hospital indemnity wellness benefit claim form - aflac accident wellness claim form - indian river - aflac wellness form - indiana in - accident claim form - good address - do not include receipts, statements, or other - accidental injury claim form - gallitz - aflac claims 1-877-44-aflac - aflac claim region - sickness claim form - good - accident wellness benefit claim form - fire fighters of ma - wellness benefit claim form - mg/ml - aflac cancer wellness benefit claim form - alba, alaska - critical illness wellness benefit claim form - do not include receipts, statements, or other - cancer wellness benefit claim form - alba, alaska - accidental injury claim form - district home - good - cancer claim form - todd peter - aflac cancer care - aflac logo - aflac quick tips for filing claims - yola - do not include receipts, statements, or other - section 2 policy benefits - gateway insurance - aflac group critical illness - accidental injury claim form - start here, get there.

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Modules: Please send the pathology relationship used in the diagnosis of malicious cancer, the applicant's birth certificate, and all detailed medical invoices with the diagnosis and codes of procedure, as well as a signed and dated authorization for disclosure of health information (HIPAA module). If your wound occurred at work, a first injury report presented to your employer must be attached to the completed request form. Compensation request form for short duration invalidity / long-term invalidity File to Hospital Claim File A Hospital Claim Online Select "Online File" below and follow the instructions. Compensation request form for benefits in the event of an accelerated death of the beneficiary for the compensation request form for death if it is a term sponsored by the employer with the number of policy starting with AFL, use i The following modules. The employer is responsible for the of the information referred to in Part B and the attending physician is responsible for the provision of the information referred to in Part C. Please dating and sign all the requested modules, where indicated. Furthermore, if you are registering during the first year of the validity date of the coverage, you will need to provide provide Information required in forms: Critical Disease Compensation Request Form File a Hospital Compensation Request File a Hospital Compensation Request by Fax or Mail A hospital Compensation Request requires supporting documentation for review of benefits, detailed invoices showing dates of medical care and diagnostic conditions, documents for hospitalization and confinement, pharmacy receipts for reimbursement of prescribed medications and a signed and dated authorization for disclosure of health information (HIPAA form i. If you were first treated in an emergency department, you will need a copy of your hospital discharge documents to verify the first date of treatment, diagnosis and procedure. Medical declaration form Online file a critical disease complaint by fax or mail For critical disease complaints, we need information from you and your treating physician. Modules: Complaints about Critical Group Diseases Submit a Dental Complaint Submit a Dental Complaint by fax or mail Please complete the Patient section, boxes 8A*18, and the Insured/Employee section (excluding boxes 31A*38 and 40.) The dentist must complete the section Dentist billing, boxes 42A*66 (except box 53). Send to: PO Box 60 676, Worcester, MA 01 606 Death Benefit Request Forms Accelerated Death Benefit Request Form Death Benefit Request Form Waive Death Benefit Request Form-Continuance of Long Term Care Benefit Request Form / Home Care Request Forms Change Your Name Change Your Beneficiary Secondary Recipient Bank Automatic Draft / Funds Transfer Request Loan Request Return Life Request Partial Return Life Request Change of ownership Change of net (date of birth) Removal of Riders New York Domestic Violence Notice (For Life Insurance Policy Holders) Lost Check Agreement Authorization to obtain information Form Authorization to obtain information Form Please date and sign all required forms Indicated. Provide all the information requested in Part A of the initial application form. If you are applying for a healthcare screening on your hospital indemnity, accident, or critical disease plan for the Coronavirus test (Covid-19), select biometric screening as an exam. Files online file An accident request by fax or mail Please provide a complete date and description of your injury. Below are the average costs of common lesions: Broken leg: \$ 7.274 2 Thermal burn: \$ 3.020 9 Fractured ankle: \$ 2.500 10 Cerebral emotion: \$ 800 11 Acl Tear: \$ 14.800 12 Even with important medical insurance coverage, you could Still tiny thousands of out-of-pocket dollars. Please include all the treatment dates and expenses incurred due to the injury. Insurance coverage 60% Residual fees A € \$ 2.910 Accident up to \$ 0 Hospital up to \$ 0 Request an Aflac wellness benefit here to help you. Furthermore, if the registration takes place during the first year of the effective date of the coverage, you will need to provide the requested information in the pre-existing investigation declaration. Modules: Hospitalization request form Print a universal life insurance request signed by TrustMark Insurance Company Universal life insurance subscribed by TrustMark Insurance Company To submit a compensation request, simply select the appropriate request form for your Specific product and send it via email or send it by fax to the address indicated in the form. Please provide all the information requested in the part A «Statement of the insured» of the request form. 3. Performance in the event of death request form of compensation for life renounces the premium compensation request form to present a request for compensation Universal life underwritten by Trustmark Insurance Company Universal claim underwritten by Trustmark Insurance Company To submit a claim, simply select the appropriate claim form for your specific product and fax it to the address shown on the form. Send to: PO Box 60 676, Worcester, MA 01 606 Claim Form NY a Claim Form for Death Benefit NY a Accelerated Death Accelerated Death Claim Form NY - Waiver of premium claim application-Initial submission of premium Classification Form-Continuance NY - Waiver of premium application Form-Permanent NY - Care of benefits for permanence Form of service Forms of service Change your name change your beneficiary Recipient Secondary Bank Bank Draft / Electronic funds Transfer request Request Request Application for Loan Surrender Application for Partial Life Surrender Change of Ownership Change of Age (Birthdate) Removal of New York Drivers Domestic Violence Notice (for life insurance Insured insurance) Shortcuts check to get the authorization of the information form to get the information form please date and sign all mods required forms where indicated. Once completed, please return it to: Continental American Insurance Company Insurance Mail: Post Office Box 84 075, Columbus, GA 31 993 Phone: 800.433.3036 Phone: 800.433.3036 Fax: 866.849.2970 Email: GroupClaim MaimFiling@aflac.com Forms: for direct filing of claims Waiver of Premium Form Payment of the Premium DATA form and sign all required forms where indicated. 2. You can provide this information in the space designated on the application form. Complaints are subject to political terms and conditions. Please Timers and sign all required forms where indicated. File Online File A Hospital by Fax or Mail A Hospital Benefit Claim Requires supporting documentation for the review of benefits, detailed invoices showing dates of medical treatment and diagnosed conditions, hospital admission documents and decorations for hospital admission and confinement benefits, pharmacy receipts for reimbursement of hospital admission prescription and a signed and dated authorisation for the disclosure of health information out out li eredeitlic id agerp is .onlho actirc aittalam id enoizacidnevir anu oratneserp id amir* .onlho actirc aittalam id enoizacidnevir anU elif acitirc aittalam id enoizacidnevir anU elif oppurG led orncac led inoizacidnevir iludOM .otuges id iludom eud i olos erazzliltu .1987654321 -oppmese .ocitremun erolv au ni ni " A et a otacsair otats " A otacitreec led oremun li es iludOM .gva 472,7 \$ ovitvevrrp nu neititO .JAAPIH To complete and return the doctor's statement form * If your doctor has already completed and returned this module, select "Online File" below and follow the instructions. The part of the medical care request form a € must be completed by the doctor who has first diagnosed the disease. Download the form. Modules: Compensation request file for critical disease disease Compensation request for critical disease by fax or e-mail for claims for critical disease, we need information from you and your doctor. If the accident was caused by the use of one or more motor vehicles, a copy of the police report or accident is needed. This module can be used for all product claims, with the exception of group duration claims, the whole life of the group and AD & D. Furthermore, please read and sign authorization for the dissemination of health information (HIPAA module) included in Part A, as well as the separate authorization for the dissemination of health information (HIPAA module). Online Archive A wellness benefit by fax or mail Please complete the request form for wellness benefit. Modules: file of the compensation request form for group injuries at Benextend Compensation requests for group injuries at Benextend requires support documentation for reviewing benefits such as a detailed invoice if there was a hospital stay, detailed invoice by 'doctor's office, surgical relationship if the intervention took place, diagnostic / xray test reports with dates and charges, if applicable, accident ratio if applicable, and a signed and dated authorization for the dissemination of health information (form HIPAA). 1. forms: assistance request form stores a compensation instance for and online Incident Claim Select "File Online" below and follow the instructions. Please submit the required medical documentation for the specific covered critical disease, the applicant's birth certificate, a list of the names of all doctors and hospitals in the appropriate section, as well as a signed and dated for the dissemination of health information (HIPAA module). If the cause of death is an injury or accident, please attach a copy of all police reports and/or related newspaper articles. Fill it out. Modules: Incident Wellness Claim Form Critical Malness Wellness Claim Form File an Accident Claim File an Incident by fax or mail Please provide a complete date and description of your incident. Modules: File a Group Life Insurance or Accidental-Death and Dismemberment Insurance Rider Claim Group Life Insurance or Accidental-Death and Dismemberment Insurance Rider Claims Please provide a certified copy of the birth and death certificate of the deceased person. Modules: Invalidity claim file group Dental Claims File a Disability Claim File a Disability via Fax or Mail For disability claims, we will need information from you, your employer and your doctor. doctor.

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