



# VISION CLAIM FORM – PHYSICIAN’S STATEMENT

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

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.

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: \_\_\_\_\_

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## 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  
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)

## 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, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999, as soon as possible in order to expedite claim review.

Policyholder Name:	Policy Number(s):	Date of Birth:
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Policyholder Address:

Claimant/Patient Name (if different from named policyholder listed above):	Date of Birth:
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<p><b>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:</b></p>	<p><b>Name and Address of health care provider(s), company, or individual authorized to release the requested information:</b> (this section will be completed by Aflac):</p>
<p><b>Purpose of Disclosure:</b> Evaluate claims for benefits during the time this authorization is valid.</p>	

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, or the presence of a communicable or noncommunicable disease.
  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.
  5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

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

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