SICKNESS CLAIM FORM P∅A2Z9Y1

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

FILING CLAIM FOR (check all that apply):

☐ Sickness ☐ Pregnancy ☒ Hospitalization ☐ Deceased - Date Deceased: ____/____/____

Cancer Policy Number	Short-Term Disability/ Sickness Disability Rider Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number	CareAssist Policy Number	Life Policy Number	Specified Health Event Policy Number
		A46200TX				

P∅A2Z9Y1

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

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

Policyholder Information
(Please print.)

First Name: Diane Initial: C Last Name: Huth

Mailing Address: 12802 Vidorra Circle

City: San Antonio State: TX ZIP: 78216

Check box if this is a new permanent address: ☐

Social Security Number: 263-78-9775

Phone Number: (210) 601-7852

Patient Information
(Please print.)

First Name: David Initial: P Last Name: Jensen

Relationship: ☐ Primary Policyholder ☒ Spouse ☐ Dependent Child

Sex: ☒ Male ☐ Female

Patient Birth Date: 11-23-48

☐ Check here if dependent 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: [signature]

FAMILY RELATIONSHIP, IF NOT POLICYHOLDER: Spouse

DATE: 8/28/13

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)

PØA2Z9Y1

SICKNESS 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 cri[...] person to criminal and civil penalties.

Policy Number: PØA2Z9Y1 Policyholder Name: Diane C. Huth

Patient Name: David P. Jensen Date of Birth: 11-23-48

SECTION B: PHYSICIAN'S STATEMENT Please answer each question **COMPLETELY.**

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

DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION	PLACE OF SERVICE

1. Symptoms first occurred on: ____/____/____ If diagnosed with cancer, date of initial diagnosis: ____/____/____
2. Patient first consulted you for this condition on: ____/____/____
3. Was the patient referred to you by another physician? ☐ Yes ☐ No

   If yes, physician's name: ________

   Referring physician's address: ________ Phone number: ________
4. Was patient hospitalized as a result of this diagnosis? ☒ Yes ☐ No

   Admission: ____/____/____ Discharge: ____/____/____

   Hospital Name: University Hospital

   City: San Antonio State: TX
5. Was patient treated in an emergency room of a hospital as a result of this diagnosis? ☒ Yes ☐ No

   Hospital Name: University Hospital - San Antonio Date of treatment: ________
6. Pregnancy claims: Date of delivery: ____/____/____ ☐ Vaginal ☐ Cesarean
7. If not delivered, expected delivery date: ____/____/____

   Please advise of any complications. ________

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)

A462007X PØA2Z9Y1

Claims Authorization to Obtain Information

AU

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: Diane C Huth	**Policy Number(s):** A462007X	**Date of Birth:** 10-20-50
Policyholder Address: 12802 Vidorra Circle Dr, San Antonio TX 78216		
Claimant/Patient Name (if different from named policyholder listed above): David P. Jensen		**Date of Birth:** 11-23-48

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.

Name and Address of health care provider(s), company, or individual authorized to release the requested information:
(this section will be completed by Aflac):

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.

[signatures] 8/24/13

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

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

PØA2Z9Y1

User: ACC72660 UNIVERSITY HEALTH SYSTEM Printed: 08/27/2013 01:11PM

Detail Charges for: JENSEN,DAVID MRN: 20942597 VTYP: IPACU Adm#: 138140168

Svc Date	IC	Dept	Chg Code	Description	Units	Amount	Ind
01/05/2013	206	6311	000759870	ROOM & BOARD-GEN MED,IN	1	1800.00	
01/06/2013	206	6311	000759870	ROOM & BOARD-GEN MED,IN	1	1800.00	
01/07/2013	206	6311	000759870	ROOM & BOARD-GEN MED,IN	1	1800.00	
** 206 ICU INTERMEDIATE			3 Trans	3 Units	5400.00 Dollars		
01/05/2013	250	7411	01533378	NS 250 ML.	1	60.00	
01/05/2013	250	7411	01545743	AZITHROMYCIN 500MG INJ	1	102.00	
01/05/2013	250	7411	01533742	NS 1000ML	1	60.00	
01/05/2013	250	7411	01549266	WATER, STERILE 10ML INJ	1	28.65	
01/05/2013	250	7411	01549096	CEFTRIAXONE 250MG (AS 1	4	14.55	
01/05/2013	250	7411	01532526	1/2 NS 250ML AV	1	40.00	
01/05/2013	250	7411	01544310	VANCOMYCIN INJ (PER 500	2	41.60	
01/05/2013	250	7411	01530880	NS 100 ML (MINI-BAG)	1	55.00	
01/05/2013	250	7411	01541086	PIPRACIL/TAZOBACTAM 1.1	4	119.95	
01/05/2013	250	7411	01513237	FOLIC ACID 1MG TAB.	1	3.35	
01/05/2013	250	7411	01516775	VITAMIN,MULTIPLE TAB.	1	3.00	
01/05/2013	250	7411	01533742	NS 1000ML	1	60.00	
01/05/2013	250	7411	01566943	SOD CHLORIDE 10% 15ML R	1	6.00	
01/05/2013	250	7411	01532526	1/2 NS 250ML AV	1	40.00	
01/05/2013	250	7411	01544310	VANCOMYCIN INJ (PER 500	2	41.60	
01/05/2013	250	7411	01530880	NS 100 ML (MINI-BAG)	1	55.00	
01/06/2013	250	7411	01541086	PIPRACIL/TAZOBACTAM 1.1	4	119.95	
01/06/2013	250	7411	01533742	NS 1000ML	1	60.00	
01/06/2013	250	7411	01532526	1/2 NS 250ML AV	1	40.00	
01/06/2013	250	7411	01544310	VANCOMYCIN INJ (PER 500	2	41.60	
01/06/2013	250	7411	01513237	FOLIC ACID 1MG TAB.	1	3.35	
01/06/2013	250	7411	01516287	THIAMINE 100MG TAB.	1	3.00	
01/06/2013	250	7411	01516775	VITAMIN,MULTIPLE TAB.	1	3.00	
01/06/2013	250	7411	01533378	NS 250 ML.	1	60.00	
01/06/2013	250	7411	01545743	AZITHROMYCIN 500MG INJ	1	102.00	
01/06/2013	250	7411	01530880	NS 100 ML (MINI-BAG)	1	55.00	
01/06/2013	250	7411	01541086	PIPRACIL/TAZOBACTAM 1.1	4	119.95	
01/06/2013	250	7411	01533742	NS 1000ML	1	60.00	
01/06/2013	250	7411	01532526	1/2 NS 250ML AV	1	40.00	
01/06/2013	250	7411	01544310	VANCOMYCIN INJ (PER 500	2	41.60	
01/06/2013	250	7411	01545748	ENOXAPARIN 10MG (AS 40M	4	201.50	
01/06/2013	250	7411	01530880	NS 100 ML (MINI-BAG)	1	55.00	
01/06/2013	250	7411	01541086	PIPRACIL/TAZOBACTAM 1.1	4	119.95	
01/06/2013	250	7411	01566943	SOD CHLORIDE 10% 15ML R	1	6.00	
01/06/2013	250	7411	01511048	CALCIUM CARB 650MG TAB.	1	3.00	
01/06/2013	250	7411	01532526	1/2 NS 250ML AV	1	40.00	
01/06/2013	250	7411	01544310	VANCOMYCIN INJ (PER 500	2	41.60	
01/06/2013	250	7411	01530880	NS 100 ML (MINI-BAG)	1	55.00	
01/07/2013	250	7411	01541086	PIPRACIL/TAZOBACTAM 1.1	4	119.95	
01/07/2013	250	7411	01533742	NS 1000ML	1	60.00	
01/07/2013	250	7411	01566943	SOD CHLORIDE 10% 15ML R	1	6.00	
01/07/2013	250	7411	01532526	1/2 NS 250ML AV	1	40.00	
01/07/2013	250	7411	01544310	VANCOMYCIN INJ (PER 500	2	41.60	
01/07/2013	250	7411	01511048	CALCIUM CARB 650MG TAB.	1	3.00	

University Health System
4502 Medical Dr.
San Antonio, TX 78229

PØ422941

User: ACC72660 UNIVERSITY HEALTH SYSTEM Printed: 08/27/2013 01:11PM

Detail Charges for: JENSEN,DAVID MRN: 20942597 VTYP: IPACU Adm#: 138140168

Svc Date	IC	Dept	Chg Code	Description	Units	Amount	Ind
01/07/2013	250	7411	01513237	FOLIC ACID 1MG TAB.	1	3.35	
01/07/2013	250	7411	01516287	THIAMINE 100MG TAB.	1	3.00	
01/07/2013	250	7411	01516775	VITAMIN,MULTIPLE TAB.	1	3.00	
01/07/2013	250	7411	01545748	ENOXAPARIN 10MG (AS 40M	4	201.50	
01/07/2013	250	7411	01533378	NS 250 ML.	1	60.00	
01/07/2013	250	7411	01545743	AZITHROMYCIN 500MG INJ	1	102.00	
01/07/2013	250	7411	01530880	NS 100 ML (MINI-BAG)	1	55.00	
01/07/2013	250	7411	01541086	PIPRACIL/TAZOBACTAM 1.1	4	119.95	
01/07/2013	250	7411	01532526	1/2 NS 250ML AV	1	40.00	
01/07/2013	250	7411	01544310	VANCOMYCIN INJ (PER 500	2	41.60	
01/07/2013	250	7411	01530880	NS 100 ML (MINI-BAG)	1	55.00	
01/07/2013	250	7411	01541086	PIPRACIL/TAZOBACTAM 1.1	4	119.95	
01/08/2013	250	7411	01530880	NS 100 ML (MINI-BAG)	1	55.00	
01/08/2013	250	7411	01541086	PIPRACIL/TAZOBACTAM 1.1	4	119.95	
01/08/2013	250	7411	01517192	KCL 20 MEQ TAB	2	8.30	
01/08/2013	250	7411	01511089	AZITHROMYCIN ORAL (UP T	1	103.65	
01/08/2013	250	7411	01513237	FOLIC ACID 1MG TAB.	1	3.35	
01/08/2013	250	7411	01516775	VITAMIN,MULTIPLE TAB.	1	3.00	
01/08/2013	250	7411	01545748	ENOXAPARIN 10MG (AS 40M	4	201.50	
01/08/2013	250	7411	01517192	KCL 20 MEQ TAB	2	8.30	
** 250 PHARMACY			64 Trans	109 Units	3580.15 Dollars		
01/05/2013	255	7661	00450686	OMNIPAQUE CT 350 P/ML	100	46.00	
** 255 DRUGS/RADIOLOGY			1 Trans	100 Units	46.00 Dollars		
01/05/2013	260	6111	00320417	INFUSION THERAPY FIRST	1	240.00	
01/05/2013	260	6111	00320418	INFUSION THERAPY EA ADD	1	95.00	
01/05/2013	260	6111	00320419	IV PUSH EA ADDL DIFF DR	1	45.00	
** 260 IV THERAPY			3 Trans	3 Units	380.00 Dollars		
01/05/2013	270	6111	00320416	PULSE OX PROBE	1	33.00	
01/05/2013	270	6111	00323170	BP CUFF-DISPOSABLE..	1	12.00	
** 270 MED-SUR SUPPLIES			2 Trans	2 Units	45.00 Dollars		
01/06/2013	300	7301	00107719	PHLEBOTOMY SKIN PUNCTUR	1	13.00	
01/07/2013	300	7301	00107719	PHLEBOTOMY SKIN PUNCTUR	1	13.00	
01/05/2013	300	6111	00323046	VENIPUNCTURE,,,,,	2	26.00	
** 300 LABORATORY			3 Trans	4 Units	52.00 Dollars		
01/05/2013	301	7231	00100005	BASIC METABOLIC PANEL	1	154.00	
01/05/2013	301	7231	00100007	COMPREHENSIVE METABOLIC	1	237.00	
01/05/2013	301	7231	00101257	CHLORIDE/URINE	1	69.00	
01/05/2013	301	7231	00105112	VANCOMYCIN LEVEL	1	163.00	
01/05/2013	301	7231	00105112	VANCOMYCIN LEVEL	1	163.00	
01/05/2013	301	7231	00105392	POTASSIUM,URINE	1	63.00	
01/05/2013	301	7231	00105937	SODIUM,URINE	1	63.00	
01/05/2013	301	7231	00107662	OSMOLALITY, URINE	1	73.00	
01/06/2013	301	7231	00100005	BASIC METABOLIC PANEL	1	154.00	
01/06/2013	301	7231	00101924	DRUG SCR QL MULTI CLASS	1	189.00	
01/06/2013	301	7231	00104078	MAGNESIUM/SERUM	1	77.00	
01/06/2013	301	7231	00105147	PHOSPHORUS/SERUM	1	61.00	
01/06/2013	301	7231	00106410	SGPT (ALANINE AMINOTRAN	1	61.00	
01/07/2013	301	7231	00100005	BASIC METABOLIC PANEL	1	154.00	

University Health System
4502 Medical Dr.
San Antonio, TX 78229

User: ACC72660

UNIVERSITY HEALTH SYSTEM

Printed: 08/27/2013 01:11PM

Detail Charges for: JENSEN, DAVID MRN: 20942597 VTYP: IPACU Adm#: 138140168

Svc Date	IC	Dept	Chg Code	Description	Units	Amount	Ind
01/07/2013	301	7231	00104078	MAGNESIUM/SERUM	1	77.00	
01/07/2013	301	7231	00105147	PHOSPHORUS/SERUM	1	61.00	
01/08/2013	301	7231	00100005	BASIC METABOLIC PANEL	1	154.00	
01/08/2013	301	7231	00104078	MAGNESIUM/SERUM	1	77.00	
01/08/2013	301	7231	00105147	PHOSPHORUS/SERUM	1	61.00	
01/08/2013	301	7171	00120784	PROCALCITONIN	1	209.00	
** 301 LAB/CHEMISTRY			20 Trans	20 Units	2320.00 Dollars		
01/05/2013	302	7171	00120286	HIV 1/2 COMBO	1	154.00	
01/05/2013	302	7171	00120833	HEPATITIS C AB SCREEN C	1	163.00	
01/06/2013	302	7171	00124079	RPR...	1	78.00	
01/08/2013	302	7171	00120122	COCCIDIOIDES SERUM IGG	1	59.00	
01/08/2013	302	7171	00120124	COCCIDIOIDES SERUM IGM	1	23.00	
01/08/2013	302	7171	00125156	ASPERGILLUS AB-R	1	62.00	
01/08/2013	302	7171	00125318	HISTOPLASMIN CF-SERO	1	71.00	
** 302 LAB/IMMUNOLOGY			7 Trans	7 Units	610.00 Dollars		
01/05/2013	305	7261	00130047	CBC W/DIFF	1	125.00	
01/05/2013	305	7261	00130047	CBC W/DIFF	1	125.00	
01/06/2013	305	7261	00130045	CBC,ONLY	1	75.00	
01/06/2013	305	7261	00136611	INR.	1	74.00	
01/06/2013	305	7261	00137685	PARTIAL THROMBOPLASTIN.	1	97.00	
01/07/2013	305	7261	00130045	CBC,ONLY	1	75.00	
01/08/2013	305	7261	00130045	CBC,ONLY	1	75.00	
** 305 LAB/HEMATOLOGY			7 Trans	7 Units	646.00 Dollars		
01/05/2013	306	7281	00120324	CULTURE/BLOOD/MICRO	1	231.00	
01/05/2013	306	7171	00125372	LEGIONELLA ANTIGEN-EIA	1	81.00	
01/05/2013	306	7281	00120324	CULTURE/BLOOD/MICRO	1	231.00	
01/06/2013	306	7281	00120421	CULTURE/URINE/MICRO	1	139.00	
01/06/2013	306	7171	00120669	DETECT AGENT NOS, DNA A	1	75.00	
01/06/2013	306	7171	00120669	DETECT AGENT NOS, DNA A	1	75.00	
01/06/2013	306	7171	00120669	DETECT AGENT NOS, DNA A	1	75.00	
01/06/2013	306	7171	00120669	DETECT AGENT NOS, DNA A	1	75.00	
01/06/2013	306	7171	00120669	DETECT AGENT NOS, DNA A	1	75.00	
01/06/2013	306	7171	00120669	DETECT AGENT NOS, DNA A	1	75.00	
01/06/2013	306	7171	00120669	DETECT AGENT NOS, DNA A	1	75.00	
01/06/2013	306	7281	00124753	CULTURE MYCOBACT CONC+I	1	234.00	
01/06/2013	306	7281	00121878	GRAM STAIN - MICRO	1	70.00	
01/06/2013	306	7281	00124753	CULTURE MYCOBACT CONC+I	1	234.00	
01/07/2013	306	7281	00124753	CULTURE MYCOBACT CONC+I	1	234.00	
01/08/2013	306	7281	00121878	GRAM STAIN - MICRO	1	70.00	
01/08/2013	306	7281	00123765	CRYPTOCOCCUS AG/EIA SCR	1	143.00	
01/06/2013	306	7281	00129991	CULTURE CONFIRM MAC PRO	1	161.00	L
** 306 LAB/BACT-MICRO			18 Trans	18 Units	2353.00 Dollars		
01/06/2013	307	7231	00106747	URINALYSIS/CHEM ONLY.	1	39.00	
** 307 LAB/UROLOGY			1 Trans	1 Units	39.00 Dollars		
01/05/2013	324	7611	00461318	CHEST 2 VIEWS	1	165.00	
** 324 DX X-RAY/CHEST			1 Trans	1 Units	165.00 Dollars		
01/05/2013	350	7661	00450642	CT - CHEST (+ CONTRAST	1	2445.00	
** 350 CT SCAN			1 Trans	1 Units	2445.00 Dollars		

University Health System
4502 Medical Dr.
San Antonio, TX 78229

PØA22941

Detail Charges for: JENSEN,DAVID MRN: 20942597 VTYP: IPACU Adm#: 138140168

Svc Date	IC	Dept	Chg Code	Description	Units	Amount	Ind
01/05/2013	450	6111	00320350	EMER RM LEV 5	1	2396.00	
** 450 EMERG ROOM			1 Trans	1 Units	2396.00 Dollars		
01/05/2013	730	6111	00323198	EKG...	1	144.00	
01/07/2013	730	7951	00431028	EKG 12-14 LEAD.	1	144.00	
** 730 EKG/ECG			2 Trans	2 Units	288.00 Dollars		
**** Visit Totals			134 Trans	279 Units	20765.15 Dollars		

End of Report

University Health System
4502 Medical Dr.
San Antonio, TX 78229