



Allstate

Benefits

OUTPATIENT PHYSICIAN'S TREATMENT CLAIM FORM

If you have any questions regarding benefits available, or how to file your claim, or if you would like to appeal any determination, please contact our Customer Care Center at 1-800-348-4489, 8:00 A.M. to 8:00 P.M. Eastern Standard Time or visit our website at www.allstateatwork.com

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

Mail or Fax Your Claim to: American Heritage Life Insurance Company 1776 American Heritage Life Drive, Jacksonville, FL 32224 Phone 1-800-348-4489 Fax 1-866-424-8482 Or visit our website at www.allstateatwork.com	
---	--

POLICYHOLDER / CERTIFICATEHOLDER INFORMATION

POLICY NUMBER(s): 1) _____ 2) _____ 3) _____

POLICYHOLDER INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: ____/____/____ Age: _____ Male Female

Mailing Address: _____ Apt#: _____

Check here if address is new

City: _____ State: _____ Zip: _____

Phone #: (____) _____ E-mail: _____

PATIENT'S INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: ____/____/____ Age: _____ Male Female

Relation to Insured: Self Spouse Child Other

OUTPATIENT PHYSICIAN'S TREATMENT BENEFIT The benefit described below is available for Outpatient Physician's Treatment. Please attach the required documentation requested. If additional information is needed, you will be notified.

Outpatient Physician's Treatment Benefit The outpatient physician treatment benefit is for treatment provided by a physician outside of the hospital. The visit may be provided for a sickness, accident, well exam, physical exam, eye exam or dental exam. Please refer to your policy for the specific benefit information.	REQUIRED DOCUMENTATION: Please provide the following: Provider Name: _____ Provider Address: _____ Date(s) of service: ____/____/____ and ____/____/____ Please attach a copy of a bill or documentation of treatment provided by a physician, outside of the hospital.
--	---

ASSIGNMENT OF BENEFITS (n/a in New Hampshire)

I request that American Heritage Life Insurance Company send benefits to someone other than me. Please send available benefits to the name and address shown below. PLEASE BE ADVISED THAT IF YOU ARE COVERED BY MEDICAID, WE MAY BE REQUIRED TO ASSIGN BENEFITS (except disability) TO THE PROVIDER OF SERVICE IN ACCORDANCE WITH STATE AND FEDERAL REGULATIONS.

Name: _____ Address: _____

Provider's Tax Identification Number: _____ City: _____ State: _____ Zip: _____

Relationship: _____ Signature of Policy Owner: _____ Date: ____/____/____

CERTIFICATION: Please read and sign below

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete, and correctly recorded. In order to process your claim, sign and date the authorization on the following page.

Signature: _____ Print Name: _____ Date: ____/____/____