Claim Form

If you choose to complete a paper version of this form, **PLEASE COMPLETE IT IN BLOCK CAPITALS**
You can also use our MyHealth Digital Services to submit your claim online: www.allianzcare.com/en/myhealth.html

Don't forget: You must submit your claims within the claiming deadline set out in your Benefit Guide, available at: www.allianzcare.com/en/myhealth.html

1 Patient's details

Policy number

Surname

First name(s)

Date of birth D D / M M / Y Y Y Y

Latest correspondence address

Phone (Country code) (Area code)

Email

Policyholder's name (if different from patient):

Do you have any national/public or state provided health insurance cover in your home country or country of residence e.g. National Health Insurance?

Yes ☐ No ☐

If Yes, please name the cover provided and give your reference number/identifier with the state.

2 Claimant's details (if different from the patient in section 1)

Surname

First name(s)

Date of birth D D / M M / Y Y Y Y Gender: Male ☐ Female ☐

3 Payment details

Option 1: Payment to **policyholder** ☐

Option 2: Payment to **provider of medical service** (e.g. hospital/clinic, pharmacies and diagnostic centers)* ☐

Option 3: Payment to Third Party ☐

Please tick if direct billing has been previously agreed with us ☐

Payment to be made in: Invoice currency ☐ Other currency ☐ Please specify (and ensure that your bank supports this currency)

Preferred payment method: Cheque** ☐ Bank transfer ☐ (Please provide bank details below)

Name of bank account holder

Account number

IBAN (where required)***

Sort/branch code BIC/Swift code***

Name of bank

Bank address

If you are aware of any additional information required in order to process international transactions within your country (e.g. agency code, tax ID), please list below:

Swift code of intermediary bank (where applicable)

* If you have not already paid the medical provider.
** Cheques payable to the policyholder will be sent to the correspondence address provided in section 1.
*** If your bank is **within the EU, or if your specific country requires an IBAN (e.g. Qatar, United Arab Emirates, Saudi Arabia, Angola, Tunisia, Turkey, Jordan)**, please supply **both** your IBAN and BIC/Swift code to facilitate the payment of your claim.

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orient insurance pjsc

4 Claim details

Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount charged. Please note that for costs incurred in China, you need to submit a Fa Piao invoice with all claims. If your invoice/receipt does not include the diagnosis/medical condition, you must give this information below. If there is insufficient space in the table below, please provide details on a separate page.

Description of expense/ treatment	Diagnosis/medical condition	Provider's name	Amount charged	Currency	Have you paid this bill?
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
Total Amount of Expenses (Please note that the total displayed here is only accurate when all invoices are issued in the same currency. If you are claiming costs in different currencies, please ignore the total amount displayed)					

In what country did the treatment take place?

Has pre-authorisation been obtained? Yes ☐ No ☐

Claims related to an accident or injury: Is this claim related to an accident/injury? Yes ☐ No ☐

If yes, please complete the following:

Date of accident/injury

Details of the accident/injury

Do you have any other insurance policy (e.g. Travel insurance)? Yes ☐ No ☐

If yes, please provide the following:

Name of the insurer

Policy number

Was the accident/injury caused by a third party? Yes ☐ No ☐

If yes, please complete the following:

Name of the third party

Name of the third party insurer

Third party policy number

Please send us a copy of the police report if available to: AZCclaims@nextcarehealth.com

Sections 5 and 6 are to be completed by the treating doctor unless the information is detailed in the supporting documentation (e.g. receipts or invoices).

5 Medical provider's details

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Phone (Country code) (Area code)

Fax (Country code) (Area code)

Email

6 Medical details

Has pre-authorisation been obtained? Yes ☐ No ☐

If Yes, please provide the Guarantee of Payment (GOP) reference number that relates to this treatment:

Indicate type of treatment received Elective ☐ Emergency ☐

Indicate type of condition: Acute ☐ Chronic ☐ Acute episode of chronic ☐

Please provide full details of the symptoms or medical condition requiring treatment:

ICD9/10 code/DSM-IV

Details of the symptoms or medical condition

On what date did the patient first present these symptoms to you? D D / M M / Y Y Y Y

On what date would the first onset of symptoms have been apparent to the patient? D D / M M / Y Y Y Y

Has the patient suffered from this condition previously? Yes ☐ No ☐ If Yes, when? D D / M M / Y Y Y Y

Are you aware of any treatment given for this or any related illness in the past? Yes ☐ No ☐

If Yes, please provide details

Is it likely to re-occur? Yes ☐ No ☐

Does it need rehabilitation? Yes ☐ No ☐

Is it permanent? Yes ☐ No ☐

Does it need long term monitoring, consultations, check ups, examinations or tests? Yes ☐ No ☐

Applicable to cases of pregnancy only:

Estimated date of delivery D D / M M / Y Y Y Y

Is birth of a single baby expected? Yes ☐ No ☐

If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes ☐ No ☐

If yes, please provide further details

Applicable to dental treatment claims only:

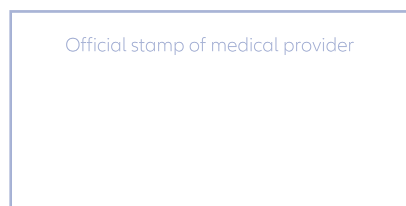
Was the patient suffering from dental pain at the time he/she visited you for treatment? Yes ☐ No ☐

Please indicate the date of onset of pain D D / M M / Y Y Y Y

Please sign and authenticate with an official stamp.

Doctor's signature

Date D D / M M / Y Y Y Y



7 Your personal data

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice visit: www.nextcarehealth.com/privacy-notice

Alternatively, you can contact us on +971 4 2708800 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by e-mail at: AZChelpline@nextcarehealth.com

Declaration

I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information. I understand that if this claim is found to be fraudulent, in whole or in part, the contract will be cancelled from the date the fraud is discovered and I may be liable to prosecution.

I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorise my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information about me, if requested by Orient Insurance PJSC, to its medical advisers or its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply.

If a minor was treated, a parent or guardian should sign and date this section.

Patient's signature ____________________ Date D D / M M / Y Y Y Y

8 We need your consent

In line with the General Data Protection Regulation (GDPR), we need your consent to process your medical information and pay your medical expenses. If you have not yet provided us with your consent, please go to my.allianzcare.com/myhealth/login, login and tick the required fields. A paper copy is available on request. Please note that every member on the policy over 18 needs to provide their own consent.

9 Third party authorisation

As the claimant I hereby authorise INSERT NAME OF THIRD PARTY

to act on my behalf in relation to the administration of this claim. This may include the disclosure of sensitive medical information.

Claimant's signature ____________________ Date D D / M M / Y Y Y Y

Claimant's printed name ____________________

Please send your fully completed Claim Form(s) with invoices/receipts by:

Email to: AZCclaims@nextcarehealth.com

Post to: Orient Insurance PJSC, 02a Orient Building, Al Badia Business Park, Dubai Festival City, P.O. Box 27966, Dubai, United Arab Emirates

It is your responsibility to retain any original supporting documentation (e.g. medical receipts) when you send us copies, as we reserve the right to request original supporting documentations up to 12 months after each claim has been settled for auditing purposes. We also reserve the right to request a proof of your payment by you (e.g. bank or credit card statement) in respect of your medical receipts. We advise you to keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.

If you have any queries, please contact our Helpline on:

Helpline: 800 6334 (toll-free from inside the UAE) or + 971 (0)56 681 9977 (from outside the UAE)

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Did you know...

...that most of our members find that their queries are handled quicker when they call us?