

4 Claim details

Please complete all parts of the following table with the details of each invoice/receipt. Please note that for costs incurred in China, you must submit a Fa Piao invoice. 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 <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
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?

Applicable to cases of pregnancy only:

Estimated date of delivery / /

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: claims.recoveries@allianzworldwidecare.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 number	COUNTRY CODE				AREA CODE																					
Fax number	COUNTRY CODE				AREA CODE																					
Email																										

Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details:

Name of referring doctor																										
Phone number	COUNTRY CODE				AREA CODE																					
Date of referral	D	D	/	M	M	/	Y	Y	Y	Y																

6 Medical details

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/medical condition


On what date did the patient first present these symptoms to you?

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

D	D	/	M	M	/	Y	Y	Y	Y
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Please sign and authenticate with an official stamp.

 Doctor's signature

Date

Official stamp of medical provider

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.allianzcare.com/en/privacy.html.


Alternatively, you can contact us on + 353 1 630 1301 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 email at: AP.EU1DataPrivacyOfficer@allianz.com

8 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 Allianz Care, 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

