



Treatment Guarantee form

Please complete this form in **BLOCK CAPITALS**.

Treatment Guarantee is not required in advance of **emergency treatment**. However either you, your physician, one of your dependants, or a colleague must inform us about your admission to hospital within 48 hours of the event.

Our Helpline (+ 852 3077 5486) can take Treatment Guarantee details over the telephone if treatment is due to take place within 72 hours. Please have as much information as possible to hand when calling, including the contact details of your doctor.

- Section 1** must be fully completed by (or on behalf of) the patient
- Section 2** must be fully completed by the doctor

Failure to complete this form in full will delay us in guaranteeing your treatment because we may have to contact you or the medical provider for further information.

The patient's policy must be in force at the time of treatment. Please note that guarantee of payment is subject to the terms and conditions of the insurance policy. It is also subject to our assessment of all the relevant documentation we need in respect of this medical condition.

1 Patient details to be fully completed by (or on behalf of) the patient

Policy number

Mr. Mrs. Ms. Miss Other First name

Surname

Date of birth / /

Contact person: please specify who we should contact regarding the progress of this Treatment Guarantee request

Name

Relationship to patient e.g. self, spouse/partner, parent

Telephone COUNTRY CODE AREA CODE

Mobile telephone COUNTRY CODE AREA CODE

Email

We care about your personal data protection

Our Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: <https://www.agcs.allianz.com/footer/privacy-notice.html>

Alternatively, you can contact us on + 852 3077 5486 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, please email us at: AP.EU1DataPrivacyOfficer@allianz.com

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 the insurer, 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 / /

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 haven't provided us with your consent, please access <https://my.allianzcare.com/myhealth/login>, login to MyHealth Digital Services and tick the required fields. Alternatively, you can download the Consent Form from www.allianzcare.com/en/consent-form. A paper copy is available on request. Please note that every member on the policy over 18 must provide their own consent.

The insurer is Allianz Global Corporate & Specialty SE (incorporated in the Federal Republic of Germany with limited liabilities), Hong Kong Branch, address Suites 403-11, 4/F, 12 Tai Koo Wan Road, Tai Koo Shing Island East Hong Kong, Hong Kong. Company Registration No. F18771.

This policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. Part of the Allianz Group, AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. Irish Branch is registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA provides administration services and technical support for the policy. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

2 Treatment details to be fully completed by the Medical Provider

- If additional treatment is required, Allianz Care must be notified.
- Please note that all invoices should be submitted within 60 days of patient discharge. However, where we have agreed special arrangements with the medical provider, these arrangements will apply.

Condition

Description of the condition, signs and symptoms

Underlying cause (if known)

Date this condition was first diagnosed / /

Date of first attendance for this condition / /

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

Diagnosis (if unknown, please state provisional diagnosis)

ICD9/10 DSM-IV DRG

Please also provide the following details for maternity cases

Date pregnancy confirmed by doctor / /

Expected or actual date of delivery / /

Is birth of a single baby expected? Yes No

If No, is the pregnancy a result of medically assisted reproduction? Yes No

Delivery method

Treatment

Planned procedure/treatment

Planned admission date / /

For treatment in the USA/UK

CPT code(s) CCSD code(s)

Description

Costs

For treatment in Germany (DRG) please confirm Base Price (Basisfallpreis)

Estimated length of stay night(s) / day(s) (tick as appropriate)

Is a package price being offered? Yes No If Yes, please state the price offered incl. currency:

If No, please provide a breakdown of estimated costs:

Hospital charges	Doctor/anaesthetist fees	Total estimated costs incl. currency
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medical provider details

Hospital/facility name

Address (including country)

Email (mandatory)

Telephone (incl. country and area codes)

Fax (mandatory) (incl. country and area codes)

Referring doctor	Attending/admitting doctor
Name <input type="text"/>	<input type="text"/>
Email (mandatory) <input type="text"/>	<input type="text"/>
Telephone (incl. country and area codes) <input type="text"/>	<input type="text"/>
Fax (mandatory) (incl. country and area codes) <input type="text"/>	<input type="text"/>

Please sign, date and authenticate with an official stamp.

I confirm that all the details given in this form are, to the best of my knowledge, true, accurate and complete.

Doctor's signature

Date / /

Official stamp of medical provider

Please send this fully completed Treatment Guarantee Form at least five working days before treatment by one of the following:

Email to: asia.medical@e.allianz.com or

Fax to: + 353 1 653 1780 or

Post to: Medical Services Department, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

We advise that you 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: + 852 3077 5486 or email: helpline.hk@e.allianz.com

For our latest list of toll-free numbers, please visit: www.allianzcare.com/toll-free-numbers