Pre-authorisation Form

Please read the guidelines overleaf, ensure that all relevant information is completed in **BLOCK CAPITALS** and that the relevant boxes are ticked.

1 Insured section - to be fully completed by the insured member/patient

Name of patient

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

Policy number

Telephone COUNTRY CODE AREA CODE

Fax COUNTRY CODE AREA CODE

Email

2 Provider section - to be fully completed by the medical provider

Hospital/facility name and address

Email

Telephone COUNTRY CODE AREA CODE

Fax COUNTRY CODE AREA CODE

Name of the attending/admitting doctor

Admission type: ☐ In-patient ☐ Out-patient ☐ Dental

Diagnosis (ICD-10) or any other code if available, otherwise a full description

Planned procedure with medical justification

For in-patient treatment

Planned admission date D D / M M / Y Y Y Y

Estimated cost (incl. currency)

Estimated length of stay

For maternity cases only

Date pregnancy confirmed by doctor D D / M M / Y Y Y Y

Expected or actual date of delivery D D / M M / Y Y Y Y

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

If No, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes ☐ No ☐

Please sign, date and authenticate with an official stamp.

Doctor's signature

Date D D / M M / Y Y Y Y

Official stamp of medical provider

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3 We care about your personal data

For your convenience, your policy is administered locally via our third party administrator, Nextcare.

Their Data Protection Notice explains how they protect your privacy and process your personal data. You must read it before sending them any personal data. To read the Data Protection Notice visit: **www.nextcarehealth.com/privacy-notice/**

Alternatively, you can contact us on **80077757** or **+968 24655801** (calling from inside Oman) or **+353 1 630 1301** (calling from outside Oman) to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, please e-mail us at: **AP.EU1DataPrivacyOfficer@allianz.com**

Declaration

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 is being treated, a parent or guardian should sign and date this section.

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

4 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 complete the Consent Form available on **www.allianzcare.com/en/consent-form** and return to us. A paper copy is available on request. Please note that every member on the policy over 18 needs to provide their own consent.

5 Third party authorisation

As the patient I hereby authorise _____ INSERT NAME OF THIRD PARTY

to act for and on my behalf in relation to the administration of this pre-authorisation which may include the disclosure of sensitive medical information.

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

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

Patient's printed name _____

To the insured member/patient

In order to ensure swift guarantee of your treatment, please ensure that you complete all questions in the insured section. Please also ensure that your doctor completes all questions in the provider section.

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 relevant documentation we need in respect of this medical condition.

To the medical provider

We guarantee payment of the expenses specified in this Pre-authorisation Form in accordance with the following conditions:

(a) The hospital will undertake the specified procedures within seven days of the date of this guarantee.
(b) If additional treatment is required, we must be notified.
(c) The hospital should submit this Pre-authorisation Form and the corresponding itemised invoices to us within 30 days of patient discharge.
(d) We will settle the guaranteed expenses within 30 days of receipt.
(e) Please note that all invoices should be submitted within 60 days of patient discharge. Where special arrangements have been agreed between us and the medical provider, these arrangements will apply.

Please send your fully completed Pre-authorisation Form by:

Email: medical.services@allianzworldwidecare.com
Fax: +353 1 653 1780
Post: 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 your 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:
80077757 or +968 24655801(calling from inside Oman)
+353 1 630 1301 (calling from outside Oman)
For our latest list of toll-free numbers, please visit: www.allianzcare.com/en/pages/toll-free-numbers.html

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