

Claim Form

Please complete this form in **BLOCK CAPITALS**. For your convenience, this form is also available on our website: www.allianzcare.com/en/support/member-resources/claim-forms.html

1 Policyholder's details

Policy Number

First name

Surname

Date of birth / /

Correspondence address

Telephone number COUNTRY CODE AREA CODE

Email

2 Patient's details (if different from policyholder)

First name

Surname

Date of birth / / Gender: Male Female

3 Payment details

Option 1: Payment to medical provider* (e.g. hospital, specialist) (The bank details requested below are not required for this option)

Option 2: Payment to policyholder (Payment under "Option 2" can only be made by cheque or bank wire transfer to the policyholder)

Preferred payment method: Bank wire transfer** Cheque***

Please specify the currency you would like to be reimbursed in (and ensure that your bank account supports it)
 Where we cannot reimburse in a local currency we will reimburse in US \$****.

Name of policyholders's bank account as shown on your bank statement

Account number

IBAN (where required)*****

Sort/branch code BIC/Swift code*****

Name of bank

ABA code ACH (for US bank accounts only)

Account beneficiary's address in the USA

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.

** For bank wire transfer, please provide bank details.

*** Cheques payable to the policyholder will be sent to the correspondence address provided in section 1. If choosing payment by cheque, please note that in some countries you might need to advise your bank to release the cheque and transfer the money into your bank account.

**** When you request a reimbursement for a claim in a foreign currency, we reserve the right to choose which currency exchange rate to apply.

***** If your bank is within the EU, or if your specific country requires an IBAN (e.g. Qatar, Saudi Arabia, Angola, Tunisia, Turkey), please supply both your IBAN and BIC/Swift code to facilitate the payment of your claim.

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. If your invoice/receipt does not include the diagnosis/medical condition, please ensure that you provide us with 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	Has this bill been paid by you?
					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"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
Total amount of expenses					
<small>(Please note that the total displayed is only accurate when all invoices are issued in the same currency. If you are claiming costs in different currencies, please disregard the total amount displayed)</small>					

In what country did the treatment take place?

Is this claim resulting from an accident or work-related illness/injury? Yes No

If yes, please provide details

If this claim is resulting from an accident or work-related illness/injury and you hold any other insurance policy e.g. car insurance or if you are filing a claim or lawsuit against a third party to recover the costs incurred as a result of this accident/injury, please provide details in a separate document.

Sections 5 and 6 are to be completed by the treating doctor unless 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

Telephone 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 physician

Telephone number COUNTRY CODE AREA CODE

Date of referral / /

