

Pre-authorisation Form

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

Pre-authorisation 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 (19154 or +20224632306) can take pre-authorisation 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.

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 Payment Guarantee 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.

Patient details to be fully completed by (or	on behalf of) the patient
Policy Number	
Mr. Mrs. Ms. Miss Other	
First name (and any middle name)	
Surname	
Date of birth DD / MM / YYYY	
ID number	
Contact person (please specify who we should contact re	garding the progress of this pre-guthorisation request)
	juicing the progress of this pre-ductions atom requesty
Name	
Relationship to patient e.g. self, spouse/partner, parent Talanhana COUNTRY AREA	
reteprione CODE CODE	
Mobile telephone CODE CODE	
Email	
important notice which outlines how we will process your process your process visit: www.allianzcare.com/en/privacy.html	ersonal data. You must read it before sending us any personal data. To read our Data Protection
* * * * * * * * * * * * * * * * * * * *	om inside Egypt) and on + 353 1 630 1301 (when calling from outside Egypt) to request a ny queries about how we use your personal data, you can always contact us by e-mail at:
health professional or other relevant medical establishme	ecy/confidentiality in respect of my medical information and I authorise my medical practitioner, to provide relevant medical information about me, if requested by Allianz Insurance Company – 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 an	date this section.
Patient's signature	Date DD / MM / YYY
We need your consent	
haven't provided us with your consent, please access https:	we need your consent to process your medical information and pay your medical expenses. If you /my.allianzcare.com/myhealth/login, login to MyHealth Digital Services and tick the required fields. w.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.

Allianz Life Assurance Company - Egypt (S.A.E) Registered Under No. 15/2001

Allianz Insurance Company - Egypt (S.A.E) Registered Under No. 13/2001

This policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. AWP Health & Life is registered in France: No. 401 154 679 RCS Bobigny. Irish Branch 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 acts as the reinsurer and provides administration and technical support for the policy. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA. The insurer is Allianz Insurance Company – Egypt (S.A.E.).

- If additional treatment is required, we 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.

Description of the conditions agriss and symotoms Checking Ch	Condition			
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Date pregnancy confirmed by doctor	ICD9/10 DSM-IV	DRG		
Expected or octuol date of delivery	Please also provide the following details for maternity ca	ases		
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	Doctor's signature			

Please send this fully completed Pre-authorisation Form at least five working days before treatment as per the below:

For treatment inside Egypt, send the completed form to us by:

Email to: cs.eg@nextcarehealth.com

+20222908220 Fax to:

Post to: Nextcare Egypt, Plot 14B01, Building A1, CFC, Fifth Settlement,

New Cairo, Egypt.

For treatment outside Egypt, send the completed form to us by:

Email to: medical.services@e.allianz.com

Fax to: + 353 1 653 1780

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