Medical Provider Claim Form

For your convenience, this form (editable PDF and editable Word version) is available on our website: www.allianzworldwidecare.com/medical-provider-claimform. If you choose to complete this form in handwriting, please use **BLOCK CAPITALS**.

Policy Number First name Summane Date of birth (selvenge) Correspondence address Telephone (seluting source) wateresselve) Final 2 Medical details Indicate type of condition: Acute Chronic Acute epocode of chronic Please provide full details of the symptomy/medical condition requiring treatment, including ICD9/10 code/DSM-IV ED9/10 code On what dake widd the insist present these symptoms to you? (selventys) On what dake widd the insist present these symptoms to you? (selventys) Has the patient suffered from this condition previously?	0	Patient details		
Surname Date of britt (superwing) Correspondence address Telephone (relading country and unescocke)		Policy Number		
Date of birth (existing survey underecoded) Correspondence readdress		First name		
Telephone (notidate) country and unecoded) Email 2 Medical details Indicate type of condition:		Surname		
Telephone (including county and annexists)		Date of birth (dd/mm/yy)		
Medical details Indicate type of condition: Acute Chronic Acute episode of chronic Please provide full details of the symptoms/medical condition requiring treatment, including ICD9/10 code/DSM-IV ICD9/10 code/DSM-IV DSM-IV DSM-I		Correspondence address		
Medical details Indicate type of condition: Acute Chronic Acute episode of chronic Please provide full details of the symptoms/medical condition requiring treatment, including ICD9/10 code/DSM-IV ICD9/10 code/DSM-IV DSM-IV DSM-I		<u> </u>		
Medical details Indicate type of condition: Acute		Telephone (including country and area codes)		
Indicate type of condition; Acute Chronic Acute episode of chronic Please provide full details of the symptoms/medical condition requiring treatment, including ICD9/10 code/DSM-IV ICD9/10 code DSM-IV DSM-IV		Email		
Indicate type of condition; Acute Chronic Acute episode of chronic Please provide full details of the symptoms/medical condition requiring treatment, including ICD9/10 code/DSM-IV ICD9/10 code DSM-IV DSM-IV				
Please provide full details of the symptoms/medical condition requiring treatment, including ICD9/10 code/DSM-IV CD9/10 code	2	Medical details		
Please provide full details of the symptoms/medical condition requiring treatment, including ICD9/10 code/DSM-IV CD9/10 code		Indicate type of condition: Acute ☐ Chronic ☐	Acute episode of chronic	
On what date did the patient flist present these symptoms to you? (dd/mm/yr) On what date would the first onset of symptoms have been apparent to the patient? (dd/mm/yr) Has the patient suffered from this condition previously? Yes No If Yes, when? (dd/mm/yr) Are you aware of any treatment given for this or any related illness in the past? Yes No If Yes, please provide details If Yes, please provide details Is it likely to re-occur? Yes No Does it need rehabilitation? Yes No Sit permanent? Yes No Does it need rehabilitation? Yes No Does it need long term monitoring, consultations, check ups, examinations or tests? Yes No Please provide the Cuarantee of Payment (COP) reference number that relates to this treatment (where available): Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/yr) Is birth of a single baby expected? Yes No If Yes, please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yr) Does of referral (dd/mm/yr) Official stamp of medical provider Please sign and authenticate with an official stamp.			·	
On what date did the patient flist present these symptoms to you? (dd/mm/yr) On what date would the first onset of symptoms have been apparent to the patient? (dd/mm/yr) Has the patient suffered from this condition previously? Yes No If Yes, when? (dd/mm/yr) Are you aware of any treatment given for this or any related illness in the past? Yes No If Yes, please provide details If Yes, please provide details Is it likely to re-occur? Yes No Does it need rehabilitation? Yes No Sit permanent? Yes No Does it need rehabilitation? Yes No Does it need long term monitoring, consultations, check ups, examinations or tests? Yes No Please provide the Cuarantee of Payment (COP) reference number that relates to this treatment (where available): Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/yr) Is birth of a single baby expected? Yes No If Yes, please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yr) Does of referral (dd/mm/yr) Official stamp of medical provider Please sign and authenticate with an official stamp.				
On what date would the first onset of symptoms have been apparent to the patient? (ddinmi/y) Has the patient suffered from this condition previously? Yes No If Yes, when? (ddinmi/yy) Are you aware of any treatment given for this or any related illness in the past? Yes No If Yes, please provide details Is it likely to re-occur? Yes No Does it need rehabilitation? Yes No Sit permanent? Yes No Does it need long term monitoring, consultations, check ups, examinations or tests? Yes No Please provide the Guarantee of Payment (GOP) reference number that relates to this treatment (where available): Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/yy) Is birth of a single baby expected? Yes No If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp.		ICD9/10 code DSM-IV		
Has the patient suffered from this condition previously? Yes No If Yes, when? (dd/mm/ly) Are you aware of any treatment given for this or any related illness in the past? Yes No If Yes, please provide details Sit likely to re-occur? Yes No	On what date did the patient first present these symptoms to you? (dd/mm/yy)			
Are you aware of any treatment given for this or any related illness in the past? Yes No If Yes, please provide details Sit likely to re-occur? Yes No				
If Yes, please provide details Sit likely to re-occur?		las the patient suffered from this condition previously? Yes 🗆 No 🗀 If Yes, when? (dd/mm/yy)		
Is it likely to re-occur? Yes No Does it need rehabilitation? Yes No Does it need rehabilitation? Yes No Does it need long term monitoring, consultations, check ups, examinations or tests? Yes No Please provide the Guarantee of Payment (GOP) reference number that relates to this treatment (where available): Applicable to cases of pregnancy only: Estimated date of delivery (adjmmlyy) Is birth of a single baby expected? Yes No If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dat/mmlyy) Official stamp of medical provider Please sign and authenticate with an official stamp.		Are you aware of any treatment given for this or any related illness in the past? Yes □ No □		
Does it need rehabilitation? Yes No Is it permanent? Yes No Does it need long term monitoring, consultations, check ups, examinations or tests? Yes No Please provide the Guarantee of Payment (GOP) reference number that relates to this treatment (where available): Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/yy) Is birth of a single baby expected? Yes No If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp.		If Yes, please provide details		
Does it need rehabilitation? Yes No Is it permanent? Yes No Does it need long term monitoring, consultations, check ups, examinations or tests? Yes No Please provide the Guarantee of Payment (GOP) reference number that relates to this treatment (where available): Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/yy) Is birth of a single baby expected? Yes No If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp.				
Is it permanent? Yes No Does it need long term monitoring, consultations, check ups, examinations or tests? Yes No Please provide the Guarantee of Payment (COP) reference number that relates to this treatment (where available): Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/ly) Is birth of a single baby expected? Yes No If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/lyy) Official stamp of medical provider Please sign and authenticate with an official stamp.				
Does it need long term monitoring, consultations, check ups, examinations or tests? Yes No Please provide the Guarantee of Payment (GOP) reference number that relates to this treatment (where available): Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/lyy) Is birth of a single baby expected? Yes No If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/lyy) Official stamp of medical provider Please sign and authenticate with an official stamp.				
Please provide the Guarantee of Payment (COP) reference number that relates to this treatment (where available): Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/yy) Is birth of a single baby expected? Yes No				
Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/yy) Is birth of a single baby expected? Yes No If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp.				
Estimated date of delivery (dd/mm/yy) Is birth of a single baby expected? Yes No If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp.				
Is birth of a single baby expected? Yes No If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp.				
If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes No If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp.				
Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp. Doctor's signature			en la companya de la	
If Yes, please provide further details Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp.			sisted reproduction other than artificial insemination?	
Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details: Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp.		100 contrary and the fresh or details		
Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp. Doctor's signature		ir res, prease provide rurtirer details		
Name of referring physician Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp. Doctor's signature				
Telephone (including country and area codes) Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp. Doctor's signature				
Date of referral (dd/mm/yy) Official stamp of medical provider Please sign and authenticate with an official stamp. Doctor's signature				
Official stamp of medical provider Please sign and authenticate with an official stamp. Doctor's signature				
Please sign and authenticate with an official stamp. Doctor's signature		Date of referral (dd/mm/yy)		
Doctor's signature			Official stamp of medical provider	
		Please sign and authenticate with an official stamp.		
		Doctor's signature		



3 Data Protection and release of medical records (to be signed and dated by the patient)

References to information includes personal information given by you to us, in your Application, Claim or Treatment Guarantee Form and/or supporting documents/information we collect in connection with products or services we provide. Allianz Worldwide Care, part of the Allianz Group, is the data controller for this information.

Uses: Personal information may be used for insurance administration (e.g. underwriting, claims handling, fraud prevention). We may use third parties to process data on our behalf. Such processing, which may take place outside the European Economic Area (EEA), is subject to contractual restrictions regarding confidentiality and security in line with Data Protection obligations.

Sensitive data: We need to collect sensitive data relating to you (e.g. health details), to assess insurance terms and/or administer claims.

Disclosure: We may share your information with our agents, members of the Allianz Group, other insurers and their agents, service providers, any intermediary acting on your behalf or governing/regulatory bodies (of which we are a member or by which we are governed). In certain circumstances, we may use private investigators to investigate a claim

Retention: We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than necessary and will hold it only for the purposes for which it was obtained.

Representation and Consent: By signing this form you confirm that you have the authority to act on behalf of your dependants in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependants.

Access: You have the right to request and receive a copy of your personal data held by us. If you wish to do this, please write to the Data Protection Officer at the address provided on this form or via client.services@allianzworldwidecare.com.

Call recording: Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent, in whole or in part, the contract may be cancelled from the date of discovery of the fraudulent event 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 relating to me, if requested by Allianz Worldwide Care, its medical advisers, 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 this section.

Patient's signature Date (dd/mm/yy)

Important – please check the following: ☐ All original receipts, invoices and prescriptions are attached. ☐ The Medical Provider Claim Form is completed in full (including GOP reference number, where available).	 The declarations are signed and dated. The diagnosis has been confirmed and is either stated on the Medical Provider Claim Form or on the invoices.

Please send the fully completed Medical Provider Claim Form(s) with original invoices attached (photocopies cannot be accepted) to the following address:

Claims Department, Allianz Worldwide 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: + 353 1 630 1301 or email: client.services@allianzworldwidecare.com. For our latest list of toll-free numbers, please visit: www.allianzworldwidecare.com/toll-free-numbers