Allianz Worldwide Care Services acting on behalf of Allianz Private Krankenversicherungs-AG

## Treatment Guarantee Form

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

Section 1

must be fully completed by (or on behalf of) the patient

Section 2

must be fully completed by the doctor

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

Our Helpline (+ **353 1 514 8456**) can take Treatment Guarantee details over the telephone if treatment is due to take place within 72 hours. Please have as many details as possible to hand when calling, including the contact details of your doctor.

Failure to complete this form fully will delay our ability to guarantee your treatment as we may have to revert to you or the medical provider for further information. The patient's policy must be in force at the time of treatment. Please be advised that guarantee of payment is subject to the terms and conditions of the insurance policy and also subject to the assessment of all relevant documentation received, or yet to be received, by Allianz Worldwide Care Services in respect of this medical condition.

PATIENT DETAILS to be fully	completed by (or on bei	half of) the pati	ent			
Policy Number						
Mr.□ Mrs.□ Ms.□ Miss□ Other						
First name						
Surname						
Date of birth DD / MM / N	/ Y					
Contact person	6 l l l. l. l		l	Maio Torrator and Con-		
Contact person please speci	fy who should be contact	ea regarding ti	ne progress of	this Treatment Gua	irantee request	
Name						
Relationship to patient e.g. self, spouse/p	artner, parent					
Telephone (Country code)	(Area code)					
Mobile telephone (Country code)	(Network code)					
Email						

The insurer of this policy is Allianz Private Krankenversicherungs-Aktiengesellschaft.

Chairperson of the Supervisory Board: Dr. Manfred Knof.
Board of Management: Dr. Birgit König (Chairperson), Daniel Bahr,
Dr. Jan Esser, Burkhard Keese, Joachim Müller, Dr. Thomas Wiesemann.
VAT Registration Number: DE 811 239 569.

Financial and insurance services are VAT exempt as per the VAT Directive.

Registered Office: München. Commercial Register: Amtsgericht München HRB 2212.

Allianz Worldwide Care Services is a registered business name of AWP Health & Life Services Limited. AWP Health & Life Services Limited provides certain administration services and technical support for this policy such as claims processing, policy administration and Helpline inside and outside of Germany. AWP Health & Life Services Limited is a limited liability company registered in Ireland. Registered Number: 509216, Registered Office: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

Chairperson of the Board of Directors: Lidia Luka-Lognoné.

Members: Clodagh Clarke, Frank Mee.





## 2 TREATMENT DETAILS to be fully completed by the Medical Provider

- If additional treatment is required, Allianz Worldwide Care Services must be notified.
- 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.

Condition												
Description of the condition, signs and symptoms												
								$\exists$	$\pm$	$\pm$		$\Box$
Underlying cause (if known)								_		$\pm$		H
	e of first attendance	for this condi	tion	D D	/ M		Y	Y				
On what date would the first onset of symptoms have been apparent to the patient?	DD/MN											
Diagnosis (if unknown, please state provisional diagnosis)												
Diagnosis (ii alikiom, piease state provisiona diagnosis)										+		
ICD9/10 DSM-IV												
Please also provide the following details for maternity cases		6 1 12										
	ected or actual date	•			M / [	Y   Y		2 .				
Is birth of a single baby expected? Yes \( \) No \( \) If <b>No</b> , is the pregnancy a result	t of medically assist	ed reproducti	on other	than ar	tificial ir	nsemir	nation	1? Y	'es L	J N	0 📙	
Delivery method												
Treatment												
Planned procedure/treatment												
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For treatment in the USA/UK			riainico	a durriis	SIOTI GG			/ L	IVI I	VI /	'	<u> </u>
CPT code(s) CCSD code(s)												
Description Cest Code (3)												
Description								_	$\perp$	$\pm$	+	
Costs  Estimated length of stay $night(s) \square / day(s) \square (tick as approximately approxi$	muinta)											
Is a package price being offered? Yes \( \text{No} \) If <b>Yes</b> , please state the price offer If <b>No</b> , please provide a breakdown of estimated costs: Hospital charges		Phys	sician/ana	aestheti	ist fees							
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Please send this fully completed Treatment Guarantee Form at least five working days prior to treatment by:

- Scan and email to: pkv.medical@allianzworldwidecare.com or
- Fax to: +353 1 653 1780 or
- Post to: Medical Services Department, Allianz Worldwide Care Services, 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.