

Pre-authorization Form

For your convenience, this form is available on our website:
www.allianzworldwidecare.com/egypt

Pre-authorization 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 (+ 20224182564 / +201145009007) can take pre-authorization 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.

Section 1 must be fully completed by (or on behalf of) the patient

Section 2 must be fully completed by the doctor

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

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 us in respect of this medical condition.

1 PATIENT DETAILS *to be fully completed by (or on behalf of) the patient*

Policy Number _____

Mr. Mrs. Ms. Miss Other _____ First name (and middle name) _____

Surname _____

Date of birth | D | D | M | M | Y | Y | _____

ID number _____

Contact person *please specify who should be contacted regarding the progress of this pre-authorization request*

Name _____

Relationship to patient e.g. self, spouse/partner, parent _____

Telephone (Country code) _____ (Area code) _____

Mobile telephone (Country code) _____ (Network code) _____

Email _____

Data Protection and release of medical records

References to information includes personal information given by you to us, in your Application, Claim or Pre-authorization Form and/or supporting documents/information we collect in connection with products or services we provide.

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 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 you have submitted.

Retention: We are obliged to retain your records for a minimum of 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 usage 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.

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

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 Insurance Company - Egypt, 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 | D | D | M | M | Y | Y | _____

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

- If additional treatment is required, we 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

Underlying cause (if known)

Date this condition was first diagnosed

D D M M Y Y

Date of first attendance for this condition

D D M M Y Y

On what date would the first onset of symptoms have been apparent to the patient?

D D M M Y Y

Diagnosis (if unknown, please state provisional diagnosis)

ICD9/10

DSM-IV

DRG

Please also provide the following details for maternity cases

Date pregnancy confirmed by doctor

D D M M Y Y

Expected or actual date of delivery

D D M M Y Y

Is 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

Delivery method

Treatment

Planned procedure/treatment

Planned admission date

D D M M Y Y

For treatment in the USA/UK

CPT code(s)

CCSD code(s)

Description

Costs

For treatment in Germany (DRG) please confirm Base Price (Basisfallpreis)

Estimated length of stay

night(s) / day(s) (tick as appropriate)

Is a package price being offered? Yes No

If Yes, please state the price offered incl. currency:

If No, please provide a breakdown of estimated costs:

Hospital charges

Physician/anaesthetist fees

Total estimated costs incl. currency:

Medical provider details

Hospital/facility name

Address (including country)

Email (mandatory)

Telephone

(Country code)

(Area code)

Fax (mandatory)

(Country code)

(Area code)

Referring physician

Name

Email (mandatory)

Telephone (incl. country and area codes)

Fax (mandatory, incl. country and area codes)

Attending/admitting physician

Name

Email (mandatory)

Telephone (incl. country and area codes)

Fax (mandatory, incl. country and area codes)

Please sign and authenticate with an official stamp.

I confirm that all the details given in this form are, to the best of my knowledge, true, accurate and complete.

Doctor's signature

Date

D D M M Y Y

Official stamp of medical provider

Please send this fully completed Pre-authorization Form at least five working days prior to treatment by:

- Scan and email to: AWCReimb@nextcare.com.eg or
- Fax to: + 20222908220 or
- Post to: NEXtCARE Egypt, 17 Al-Ahram Street, section B, floor 8, Heliopolis, Cairo, Egypt.

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: + 20224182564 / +2011455009007 or email: AWCReimb@nextcare.com.eg

This policy is supported by Allianz Worldwide Care SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. Part of the Allianz Group, Allianz Worldwide Care SA is registered in France: No. 401 154 679 RCS Paris. 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. Allianz Worldwide Care SA acts as the reinsurer and provides administration services and technical support for the policy. The insurer of this policy is Allianz Insurance Company – Egypt (S.A.E.)

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

Allianz Egypt For Financial Investments Company Commercial register no: 398608 / Cairo

Address: Plot no. 14B01 Building no. (A1), Cairo Festival City, 5th Settlement, New Cairo

Phone: (202) 232 23000 Fax: (202) 232 23001

HOTLINE
1909
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أليانز لتأمينات الحياة - مصر (ش.م.م) مسجلة تحت رقم ٢٠٠١/١٥
أليانز للتأمين - مصر (ش.م.م) مسجلة تحت رقم ٢٠٠١/١٣
أليانز مصر للاستثمارات المالية - (ش.م.م) سجل تجاري رقم ٣٩٨٦٠٨ / القاهرة
العنوان: قطعة 14B01 مبنى A1 مدينة كايرو فيستفال سيتي - التجمع الخامس
القاهرة الجديدة - القاهرة
تليفون: ٢٣٢٢ ٢٣٠٠٠ فاكس: ٢٣٢٢ ٢٣٠٠١