MEDICAL PROVIDER CLAIM FORM

For your convenience, this form (editable PDF 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.

1 PATIENT DETAILS

Policy Number

First name

Surname

Date of birth D D / M M / Y Y Y Y

Correspondence address

Telephone COUNTRY CODE AREA CODE

Email

2 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

On what date did the patient first present these symptoms to you? D D / M M / Y Y Y Y

On what date would the first onset of symptoms have been apparent to the patient? D D / M M / Y Y Y Y

Has the patient suffered from this condition previously? Yes ☐ No ☐ If Yes, when? D D / M M / Y Y Y Y

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 ☐

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 D D / M M / Y Y Y Y

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 COUNTRY CODE AREA CODE

Date of referral D D / M M / Y Y Y Y

Official stamp of medical provider

Please sign, date and authenticate with an official stamp.

Doctor's signature

Date D D / M M / Y Y Y Y

Allianz Care

TO BE SIGNED AND DATED BY THE PATIENT

3 WE CARE ABOUT YOUR PERSONAL DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit: **www.allianzworldwidecare.com/en/privacy**

Alternatively, you can contact us on **+ 353 1 630 1301** to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by email at: **AWC.DataPrivacyOfficer@allianz.com**

4 DECLARATION

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 Partners, 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 and date this section.

Patient's signature

Date D D / M M / Y Y Y Y

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 Partners, 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