Allianz Care

Claim form

Please complete this form in **BLOCK CAPITALS**. You can also use our MyHealth Digital Services to submit your claim online: **www.allianzcare.com/en/myhealth.html**

Don't forget: You must submit your claims within the claiming deadline set out in your Benefit Guide, available at **www.allianzcare.com/en/myhealth.html**

1 Patient's details

Policy number | Date of birth D D / M M / Y Y Y Y

First name

Surname

Correspondence address

Phone number COUNTRY CODE AREA CODE

Email

Policyholder's name (if different from patient)

Do you have any national/public or state provided health insurance cover in your home country or country of residence e.g. National Health Insurance?

Yes ☐ No ☐ If Yes, please name the cover provided. Please give your reference number/identifier with the state.

2 Claimant's details (if different from the patient in section 1)

First name

Surname

Date of birth D D / M M / Y Y Y Y Gender: Male ☐ Female ☐

Email

3 Payment details

Please tick one of the options below and complete the details as needed.

Option 1: Payment to medical provider* (e.g. hospital, specialist) ☐

(The bank details requested below are not required for this option.)

Option 2: Payment to member ☐

Preferred payment method: Bank transfer** (Recommended) ☐ Cheque*** ☐

(Please **specify the currency** you would like to be **reimbursed** in (and ensure that your bank account supports it)

Option 3: Payment to Third Party ☐

Name of bank account holder as shown on your bank statement

Account number

IBAN (where required)****

Sort/branch code | BIC/Swift code****

Name of bank

Bank address

ABA/ACH code (for US bank accounts only)

If you are aware of any additional information required in order to process international transactions within your country (e.g. agency code, tax ID), please list here:

Swift code of intermediary bank (where applicable)

* If you have not already paid the medical provider.

** For bank transfer, please provide bank details.

*** Cheques payable to the policyholder will be sent to the correspondence address provided in section 1.

**** If your bank is within the EU, or if your specific country requires an IBAN (e.g. Qatar, Saudi Arabia, Angola, Tunisia, Turkey), please supply both your IBAN and BIC/Swift code to facilitate the payment of your claim.

4 Claim details

Please complete all parts of the following table with the details of each invoice/receipt. Please note that for costs incurred in China, you must submit a Fa Piao invoice. If your invoice/receipt does not include the diagnosis/medical condition, you must give this information below. If there is insufficient space in the table below, please provide details on a separate page.

Description of expense/ treatment	Diagnosis/medical condition	Provider's name	Amount charged	Currency	Have you paid this bill?
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
		Total Amount of Expenses (Please note that the total displayed here is only accurate when all invoices are issued in the same currency. If you are claiming costs in different currencies, please ignore the total amount displayed)	0.00		

In what country did the treatment take place?

Claims related to an accident or injury:

Is this claim related to an accident/injury? Yes ☐ No ☐

If yes, please complete the following:

Date of accident/injury D D / M M / Y Y Y Y

Details of the accident/injury

Do you have any other insurance policy (e.g. Travel insurance)? Yes ☐ No ☐

If yes, please provide the following:

Name of the insurer

Policy number

Was the accident/injury caused by a third party? Yes ☐ No ☐

If yes, please complete the following:

Name of the third party

Name of the third party insurer

Third party policy number

Please send us a copy of the police report if available to: claims.recoveries@allianzworldwidecare.com

Sections 5 and 6 are to be completed by the treating doctor unless the information is detailed in the supporting documentation (e.g. receipts or invoices).

5 Medical provider's details

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Phone number COUNTRY CODE AREA CODE

Fax number COUNTRY CODE AREA CODE

Email

Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details:

Name of referring doctor

Phone number COUNTRY CODE AREA CODE

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

6 Medical details

Indicate type of condition: Acute ☐ Chronic ☐ Acute episode of chronic ☐

Please provide full details of the symptoms or medical condition requiring treatment:

ICD9/10 code/DSM-IV

Details of the symptoms/medical condition

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 ☐

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 twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction? Yes ☐ No ☐

If Yes, please provide details

Applicable to dental treatment claims only:

Was the patient suffering from dental pain at the time he/she visited you for treatment? Yes ☐ No ☐

Please sign and authenticate with an official stamp.

Official stamp of medical provider

Doctor's signature

Date D D / M M / Y Y Y Y

7 Your personal data

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: **www.allianzcare.com/en/privacy.html.**

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: **AP.EU1DataPrivacyOfficer@allianz.com**

8 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 if this claim is found to be fraudulent, in whole or in part, the contract will be cancelled from the date the fraud is discovered 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 about me, if requested by Allianz Care, to its medical advisers or 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

9 We need your consent

In line with the General Data Protection Regulation (GDPR), we need your consent to process your medical information and pay your medical expenses. If you have not yet provided us with your consent, please access my.allianzcare.com/myhealth/login, login to MyHealth Digital Services and tick the required fields. Alternatively, you can download the Consent Form from **www.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.

10 Third party authorisation

As the claimant, I authorise INSERT NAME OF THIRD PARTY

to act on my behalf in relation to the administration of this claim. This may include the disclosure of sensitive medical information.

Claimant's signature _____

Claimant's printed name _____

Date D D / M M / Y Y Y Y

It is your responsibility to retain any original supporting documents (e.g. medical receipts) when you send us copies, as we reserve the right to request original supporting documents up to 12 months after each claim has been settled, for auditing purposes. We also reserve the right to request a proof of your payment (e.g. bank or credit card statement) in respect of your medical receipts. We advise you to 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.

Please send your fully completed Claim Form(s) with any supporting invoices/receipts (credit card slips cannot be accepted) by:

Email to: **claims@allianzworldwidecare.com**

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

Important – please check the following:

- ☐ All receipts, invoices and prescriptions are attached
- ☐ The Claim Form is completed in full.
- ☐ The declarations are signed and dated.
- ☐ The diagnosis has been confirmed and is stated either on the Claim Form or on the invoices.
- ☐ If you have changed your contact details, please let us know on the Claim Form

Did you know...

...that most of our members find that their queries are handled quicker when they call us?

If you have any queries, please contact our Helpline: **+ 353 1 630 1301** or email: **client.services@e.allianz.com**

For our latest list of toll-free numbers, please visit: **www.allianzcare.com/toll-free-numbers**

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