

CLAIM FORM - [for use on ALLIANZ underwritten policies]

To help us provide you with a fast and efficient service, we kindly ask you to note the following:

- A fully completed form will speed up the assessment and payment of your claim
- Please complete the front page of this form and ask your treating doctor to complete the back page.
- All relevant original invoices must be attached. Unfortunately, photocopies, receipts and credit card slips cannot be accepted.
- If you are submitting invoices from Germany or the USA, or if your invoices contain details of diagnoses as well as the nature of your treatment, there is no need to complete the reverse side of this form., simply attach the original invoices.
- A separate claim form is required for every patient and each medical condition.
- We recommend that you keep copies of all documents submitted, should you require them at a later date.
- Finally we kindly ask that you complete this form in **BLOCK CAPITALS**, and post to the address below, within 3 months of the treatment date

1. Policyholders Details

Policy Number Must be completed Title

Surname First Name(s)

Correspondence address

Phone No. Daytime Evening

Fax E-mail

2. Patients Details

Title Surname First name(s)

Date of Birth (dd/mm/yy) / / Is this claim related to an accident ? Yes No

3. Payment Details

Option 1 Payment to Policyholder/Insured

Payment to be made in: Invoice currency Other currency (Please specify)

Preferred payment method: Cheque Bank Transfer (please complete bank details below)

Name of bank account

Account no. / IBAN Sort/branch code

Swift Code Bank Name

Bank Address

Option 2 Payment to Provider of Medical Services (e.g. Hospital, Specialist, MRI)

Please tick if Direct Billing has been previously agreed with Allianz Worldwide Care

4. Patient Signature and Release

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 policy will be invalidated and I will be liable for prosecution. In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Allianz Worldwide Care Limited or their appointed representatives.
If a minor was treated, a parent or guardian should sign this section.

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

TO BE COMPLETED BY THE TREATING DOCTOR IN **BLOCK CAPITALS**.

5. Medical Provider Information

Name of doctor/specialist			
Qualifications/credentials			
Name of hospital/clinic			
Address			
Phone		Fax	
Email			

6. Medical Information

Has Treatment Guarantee been obtained ? Yes No

Indicate type of treatment received ? Elective Emergency

Indicate type of condition Acute Chronic Acute episode of a chronic condition

Please provide full details of the medical condition requiring treatment, including ICD code/DSM-IV

On what date did the patient first present these symptoms to you ? Date (dd/mm/yy) / /

Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition ? Date (dd/mm/yy) / /

Are you aware of any treatment given for this or any related illness in the past ? Yes No

If Yes, please give details :

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

Name of referring physician			
Telephone number			
Date of referral (dd/mm/yy)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Applicable to dental treatment only

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

Doctors Signature	<input type="text"/>	STAMP
Date (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>	

The confidentiality of patient and member information is of paramount concern to Allianz Worldwide Care. Allianz Worldwide Care fully complies with the European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.

Send completed form to : Morgan Price Claims, c/o Allianz Worldwide Care Ltd, Claims Department, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland, Helpline +353 1 630 1301 Fax +353 1 630 1306 E-mail morgan.price@allianzworldwidecare.com