Treatment Guarantee Form

Please read the following carefully, completing all relevant information in **BLOCK CAPITALS** and ticking ☑ the relevant boxes

Allianz
Allianz Worldwide Care

Is this an extension to an existing Treatment Guarantee? Yes ☐ No ☐

If 'Yes', please provide the Treatment Guarantee ID reference number

Important information - please read carefully.

To help us process the direct settlement of your medical expenses in a timely manner, please follow the guidelines below. If you have any questions, please contact our **Helpline on + 353 1 630 1301**. You can also contact the Helpline using our **toll-free numbers**:

Toll-free numbers

Toll-free from Singapore:	800 353 1018
Toll-free from Hong Kong:	800 901 705
Toll-free from North China:	10 800 744 1259
Toll-free from South China:	10 800 441 0115
Toll-free from the USA:	1 866 266 2182
Toll-free from France, Belgium, Switzerland:	00 800 66 302 302
Toll-free from Italy:	800 088 736

To the patient.

Please ensure that **you complete sections 1, 2 and 3**, and that **your doctor completes all questions in section 4**. 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 medical assessment of all relevant documentation received, or yet to be received, by Allianz Worldwide Care in respect of this medical condition.

Please send the Treatment Guarantee Form to us at least 5 working days prior to treatment, by:

- Scan and email to **client.services@allianzworldwidecare.com** or
- Fax to **+353 1 630 1306** or
- Post to: Medical Services Department, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

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 24 hours of the event**.

Please note that our Helpline can accept Treatment Guarantee requests over the phone if treatment is due to take place **within 72 hours**. Please have as many details as possible ready to give over the phone, including the contact details of your doctor.

1 Patient section.

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

Policy number

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other

First name

Surname

Date of birth d d m m y y

2 Contact details.

Please specify who should be contacted regarding the progress of this Treatment Guarantee.

Contact 1

Name

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

Telephone COUNTRY CODE — AREA CODE —

Fax COUNTRY CODE — AREA CODE —

Email

Contact 2 (optional)

Name

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

Telephone COUNTRY CODE — AREA CODE —

Fax COUNTRY CODE — AREA CODE —

Email

3 Patient signature and release of medical records.

I hereby authorize my medical practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Allianz Worldwide Care or their appointed representatives. If a minor was treated, a parent or guardian should sign this section.

Patient's signature Date d d m m y y

To the medical provider.

- If additional treatment is required, Allianz Worldwide Care must be notified
- The hospital should submit this Treatment Guarantee Form and the corresponding invoices to Allianz Worldwide Care within 30 days of patient discharge
- If invoices are received more than 60 days after patient discharge, acceptance of liability for those expenses remains at the discretion of Allianz Worldwide Care

4 Medical certificate.

To be fully completed by medical provider.

Please tick the relevant treatment category: Medical ☐ Maternity ☐ Psychiatry ☐ Oncology ☐ Rehabilitation ☐

For in-patient/day-care treatment:

Planned admission date d d m m y y

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

Is a package price being offered? Yes ☐ No ☐

If 'No', please provide a breakdown of estimated costs including currency:

Hospital charges

Surgeon/physician fees

Anaesthetist fees

Estimated length of stay Night(s)/day(s) (delete as appropriate)

Hospital/facility name

Address (including country)

COUNTRY

Telephone COUNTRY CODE — AREA CODE —

Fax COUNTRY CODE — AREA CODE —

Email

Continued overleaf.

Medical certificate (cont.).

Details of attending/admitting physician:

Name

Telephone COUNTRY CODE — AREA CODE —

Fax COUNTRY CODE — AREA CODE —

Email

Date of first attendance for this condition? d d m m y y

Date this condition was first diagnosed? 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

Details of referring physician:

Name

Telephone COUNTRY CODE — AREA CODE —

Fax COUNTRY CODE — AREA CODE —

Email

Date of referral d d m m y y

Diagnosis:

Please provide ICD 9/ICD 10/DSM IV/DRG/other diagnosis code and a full description.

ICD 9/ICD 10 DSM IV DRG Other Code

Description

Please provide details of any current medication the patient is taking

Planned procedure/treatment:

For treatment in the USA/UK, please provide CPT/CCSD code(s) and a full description.

CPT code(s) CCSD code(s)

Description

Maternity:

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 ☐

Please sign and authenticate with an official stamp.

Doctor's signature Date d d m m y y

The confidentiality of patient and member information is of paramount concern to Allianz Worldwide Care. Allianz Worldwide Care fully complies with 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.

Official stamp of medical provider

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