Allianz Care

Pre-Authorisation Form

Pre-authorisation is not required in advance of **emergency treatment**, however either you, your doctor, one of your dependants, or a colleague need to inform us about the hospital admission **within 48 hours of the event**.

Our Helpline (+ 32 2 2106501) can take pre-authorisation details over the phone **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.

Guidelines on how to complete this form:

abc	if you are using a printed version of this form, please complete it in BLOCK CAPITALS.
Section 1	must be fully completed by (or on behalf of) the patient
Section 2	must be fully completed by the doctor

Please note that

- 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 Allianz Care 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 any middle name)

Surname

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

Contact person (please specify who should be contacted regarding the progress of this Pre-authorisation request)

Name

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

Telephone COUNTRY CODE AREA CODE

Mobile telephone COUNTRY CODE NETWORK CODE

Email

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 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 e-mail at: AP.EU1DataPrivacyOfficer@allianz.com.

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 Care, 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

2 Treatment details to be fully completed by the Medical Provider

- If additional treatment is required, you need to notify Allianz Care.
- Please note that all invoices must be submitted within 60 days of patient discharge. However, where we have agreed special arrangements with 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 Y Y

Date of first attendance for this condition 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

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 Y Y

Expected or actual date of delivery D D / M M / Y Y 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 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)

Phone (incl. country and area codes)

Fax (mandatory) (incl. country and area codes)

	Referring physician	Attending/admitting physician
Name		
Email (mandatory)		
Phone (incl. country and area codes)		
Fax (mandatory) (incl. country and area codes)		

Please sign, date 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.

Official stamp of medical provider

Doctor's signature

Date D D / M M / Y Y Y Y

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

Email to: IGOmedical@e.allianz.com or

Fax to: +32 2 210 6597 or

Post to: Medical Services Team, Allianz Care, Bd Roi Albert II 32, 1000 Brussels, Belgium.

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: + 32 2 210 6501 or email: IGOhelpline@e.allianz.com