International Healthcare Plans for Qatar

# Claim Form

Please complete this form in **BLOCK CAPITALS**. For your convenience, this form (in PDF format) is available on our website: www.allianzworldwidecare.com/cfq

## Download our MyHealth app

Quick and easy claims submission

1. Provide a few key details
2. Take a photo of your receipt(s)

And you're done

www.allianzworldwidecare.com/myhealth

## 1 Policyholder's details

Policy Number

First name

Surname

Date of birth *(DD/MM/YY)*

Latest correspondence address

Telephone number *(incl. country code and area code)*

Email

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 provide a description of the cover provided along with your reference number/identifier with the state.

## 2 Patient's details (if different from policyholder)

First name

Surname

Date of birth *(DD/MM/YY)* Gender: Male ☐ Female ☐

## 3 Payment details

**Option 1:** Payment to policyholder ☐

Preferred payment method: Bank transfer* ☐ Cheque** ☐

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

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

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 below:

Swift code of intermediary bank (where applicable)

* *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.*

**Option 2:** Payment to medical provider (e.g. hospital, specialist)**** ☐

Please tick if direct billing has been previously agreed with us ☐

**** *If you have not already paid the medical provider.*

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## 4 Claim details

**Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount charged. If your invoice/receipt does not include the diagnosis/medical condition, please ensure that you provide us with this information below. If there is not sufficient 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 | Has this bill been paid by you? |
|---|---|---|---|---|
| | | | | Yes ☐ No ☐ |
| | | | | Yes ☐ No ☐ |
| | | | | Yes ☐ No ☐ |
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| | | | | Yes ☐ No ☐ |
| | | | | Yes ☐ No ☐ |
| | | | | Yes ☐ No ☐ |
| | | | | Yes ☐ No ☐ |

In what country did the treatment take place?

Has pre-authorization been obtained? Yes ☐ No ☐

*If this claim is resulting from an accident or work-related illness/injury and you hold any other insurance policy (e.g. car insurance), or if you are filing a claim or lawsuit against a third party to recover the costs incurred as a result of this accident/injury, please provide details in a separate document.*

**Sections 5 and 6 are to be completed by the treating doctor unless 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

Telephone number *(incl. country code and area code)*

Fax number *(incl. country code and area code)*

Email

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

Name of referring physician

Telephone number *(incl. country code and area code)*

Date of referral *(DD/MM/YY)*

## 6 Medical details

Indicate type of treatment received Elective ☐ Emergency ☐

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

On what date did the patient first **present** these symptoms **to you**? *(DD/MM/YY)*

On what date would the first onset of symptoms have been **apparent to the patient**? *(DD/MM/YY)*

Has the patient suffered from this condition previously? Yes ☐ No ☐ If Yes, when? *(DD/MM/YY)*

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 *(DD/MM/YY)* 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 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 *(DD/MM/YY)*

## 7 Data Protection and release of medical records

References to information includes personal information given by you to us, in your Application, Claim or Treatment Guarantee Form and/or supporting documents/information we collect in connection with products or services we provide. Allianz Worldwide Care, part of the Allianz Group, is the data controller for this information.

**Uses:** Personal information may be used for insurance administration (e.g. underwriting, claims handling, fraud prevention). We may use third parties to process data on our behalf. Such processing is subject to contractual restrictions regarding confidentiality and security in line with Data Protection obligations.

**Sensitive data:** We need to collect sensitive data relating to you (e.g. health details), to assess insurance terms and/or administer claims.

**Disclosure:** We may share your information with our agents, members of the Allianz Group, other insurers and their agents, service providers, any intermediary acting on your behalf or governing/regulatory bodies (of which we are a member or by which we are governed). In certain circumstances, we may use private investigators to investigate a claim you have submitted.

**Retention:** We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than necessary and will hold it only for the purposes for which it was obtained.

**Representation and Consent:** By signing this form you confirm that you have the authority to act on behalf of your dependents in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependents.

**Access:** You have the right to request and receive a copy of your personal data held by us. If you wish to do this, please write to the Data Protection Officer at the address provided on this form or via client.services@allianzworldwidecare.com

**Call recording:** Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

**Direct marketing:** Personal data collected by us will not be used to contact you for direct marketing purposes, unless you have consented to this.

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 will 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 authorize my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information relating to me, if requested by Allianz Worldwide 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 this section.

Patient's signature ____________ Date *(DD/MM/YY)* __/__/__

## 8 Third party authorization

As the claimant, I hereby authorize ____________ INSERT NAME OF THIRD PARTY

to act for and on my behalf and on behalf of any dependents named on this form (where applicable) in relation to the administration of this claim, which may include the disclosure of sensitive medical information.

Claimant's signature ____________ Date *(DD/MM/YY)* __/__/__

Claimant's printed name ____________

Please send your fully completed Claim Form(s) with invoices/receipts as follows:

Scan and email to: **claims@allianzworldwidecare.com**
Fax to: **+ 353 1 645 4033**
Post to: **Claims Department, Allianz Worldwide Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland**

*It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claims settlement for auditing purposes. We also reserve the right to request a proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. 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.*

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**Please contact our Helpline if you have any queries: +353 1 517 6988 or email: client.services@allianzworldwidecare.com.**

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

**Important** - please check the following:

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