Pre-authorisation Form

You can also complete this form online at : **www.allianzcare.com/members**.

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

Our Helpline (**+60 3 92127820**) can take Pre-auhorisation details over the telephone **if treatment is due to take place within 72 hours**. Please have as much information as possible to hand when calling, including the contact details of your doctor.

Guidelines on how to complete this form:

- 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 in full will delay us in guaranteeing your treatment because we may have to contact you or the medical provider for further information.
- The patient's policy must be in force at the time of treatment.
- The guarantee of payment is subject to the terms and conditions of the insurance policy. It is also subject to our assessment of all the relevant documentation we need 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

Surname

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

Contact person: please specify who we should contact regarding the progress of this Pre-authorisation request

Name

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

Phone COUNTRY CODE AREA CODE

Mobile phone COUNTRY CODE NETWORK CODE

Email

Your personal data

Allianz's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read the Data Protection Notice, visit: **www.allianzcare.com/en/privacy.html**.

Alternatively, you can contact us on **001 803 065 171** (toll-free when calling from Indonesia) or **+60 3 92127820** (international number to call from outside Indonesia) 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**

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 the insurer, 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

We need your consent

In line with the Data Protection Regulations, we need your consent to process your medical information and pay your medical expenses. If you haven't 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.

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2 Treatment details to be fully completed by the medical provider.

- If additional treatment is required, you need to notify Allianz.
- 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? Yes ☐ No ☐

Delivery method

Treatment

Planned procedure/treatment

Planned admission date D D / M M / Y Y Y Y

For treatment in the 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 price offered incl. currency

If No, please provide a breakdown of estimated costs:

Hospital charges | Doctor/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 doctor	Attending/admitting doctor
Name		
Email (mandatory)		
Phone (incl. country and area codes)		
Fax (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 this fully completed Pre-authorisation Form at least five working days before treatment by email to: **Asia.medical@e.allianz.com**

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: **001 803 065 171** (toll-free when calling from Indonesia) or **+60 3 92127820** (international number to call from outside Indonesia), or email: **asia.helpline@e.allianz.com**
For our latest list of toll-free numbers, please visit: **www.allianzcare.com/toll-free-numbers**

The policies are issued and covered by PT Asuransi Central Asia. Registered address: Mal Ambasador Ruko 2-3, Jl. Prof. Dr. Satrio, Jakarta 12940, Indonesia.
This insurance product belongs to PT Asuransi Central Asia. PT Asuransi Central Asia is responsible for the issuance of the policy and has the right to reject claims made not in accordance with the terms and conditions written in the policy.