# Pre-authorisation Form

For your convenience, this form is also available on our website: **www.allianzcare.com/en/support/member-resources/pre-authorisation-process-and-forms.html**

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

Our Helpline (**+ 353 1 630 1301**) can take Pre-authorisation details over the telephone – this will give us the opportunity to arrange for direct settlement, where possible. 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:**

- If you are using a printed version of this form, please complete this form 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.
- Pre-authorisation 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

**Privacy Notice**

Allianz México, S.A. Insurance Company (hereinafter, 'Allianz') with address located at Boulevard Manuel Ávila Camacho No. 164, Colonia Lomas de Barrilaco, Mayor's Office Miguel Hidalgo, C.P. 11010, in Mexico City, Mexico, will use your personal data collected here to: A) verify, confirm and validate your identity; B) evaluate your insurance application and risk selection or the circumstances to, where appropriate, enter into contracts with Allianz; C) comply with the obligations derived from the insurance contract that, where appropriate, is entered into; D) deliver all the documentation that is derived **from the insurance contract that, where appropriate, is entered into; E) operate and monitor the insurance product requested or contracted with Allianz; and F) prevent and detect fraud and / or illegal operations**.

For more information about the treatment and the rights that you can assert, you can access the comprehensive privacy notice through our website: www.allianz.com.mx/aviso-de-privacidad (only available in Spanish).

**We need your consent**

In line with the General Data Protection Regulations, we need consent to process your medical information and pay your medical expenses. If you have not yet provided us with your consent, please access **my.allianzcare.com/myhealth/login**, login to MyHealth digital services and tick the required fields. A paper copy is available on request. Please note that every member on the policy over 18 must provide their own consent.

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, 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.
- 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 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 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) | |

| | Referring doctor | Attending/admitting doctor |
|---|---|---|
| Name | | |
| Email (mandatory) | | |
| Phone (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 before treatment by email to: **medical.services@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 us:
Helpline : **+353 1 630 1301**
Email: **client.services@e.allianz.com**
For our latest list of toll-free numbers, please visit: **www.allianzcare.com/en/pages/toll-free-numbers.html**



This document is an English translation of a Spanish document. The Spanish version is the original and official version. If differences exist between this translation and the Spanish version, please note that the Spanish version is the legally binding and official version.

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