International Healthcare Plans for Qatar

PRE-AUTHORIZATION FORM

Please read the guidelines overleaf and ensure that all relevant information is completed in BLOCK CAPITALS and that the relevant boxes are ticked.

Pre-authorization 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**.

Section 1 must be fully completed by (or on behalf of) the patient
Section 2 must be fully completed by the doctor

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. Please note that pre-authorization 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

Name of patient

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

Policy number

Phone number Country code Area code

Fax Country code Area code

Email

WE CARE ABOUT YOUR PERSONAL DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice visit: **www.allianzcare.com/en/privacy.html**

Alternatively, you can contact us on 8000 155 (calling toll-free from within Qatar) or +974 4031 8444 (calling from within or outside of Qatar) 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: AWC.DataPrivacyOfficer@allianz.com

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 about me, if requested by Allianz Care, 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 is being 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 General Data Protection Regulation (GDPR), we need consent to process your medical information and pay your medical expenses. If you haven't provided us with your consent, please access **my.allianzworldwidecare.com**, login to Online Services and tick the required fields. Alternatively, you can download the Consent Form, available at **www.allianzworldwidecare.com/en/consent-form/**. A paper copy is available on request. Please note that every member on the policy over 18 needs to provide their own consent.

Allianz Care

2 TREATMENT DETAILS - TO BE FULLY COMPLETED BY THE MEDICAL PROVIDER

We guarantee payment of the expenses specified in this Pre-authorization Form in accordance with the following conditions:

(a) The hospital will undertake the specified procedures within 90 days of the date of this guarantee.
(b) If additional treatment is required, we must be notified within 48 hours.
(c) The hospital should submit this Pre-authorization Form and the corresponding itemised invoices to us within 30 days of patient discharge.
(d) We will settle the guaranteed expenses within the payment terms specified in your provider agreement.
(e) Please note that all invoices should be submitted within 60 days of patient discharge. However, where we have agreed special arrangements with the medical provider, these arrangements will apply.

Hospital/facility (name and address)

Email

Phone number Country code Area code

Fax Country code Area code

Name of the attending/admitting doctor

Admission type: In-patient ☐ Out-patient ☐ Dental ☐

Diagnosis (ICD-10), otherwise a full description

Planned procedure with medical justification, including CPT or DRG codes

For in-patient treatment:

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

Estimated costs Hospital costs Doctor fees

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

Maternity:

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 ☐

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 PER-AUTHORIZATION FORM AT LEAST FIVE WORKING DAYS BEFORE TREATMENT BY ONE OF THE FOLLOWING:

Email to: medical.services@allianzworldwidecare.com or
Fax to: + 353 1 653 1780 or
Post to: Medical Services Department, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

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: +974 4031 8444 or client.services@allianzworldwidecare.com
For our latest list of toll-free numbers, please visit: www.allianzworldwidecare.com/toll-free-numbers