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Medical Provider Claim Form

You can also complete this form online on our website: www.allianzcare.com/medical-provider-claimform If you choose to complete a printed version of this form, please use BLOCK CAPITALS.

Patient's details		
Policy number		
First name		
Surname		
Date of birth DDD / MM M / YYYY		
Correspondence address		
Phone COUNTRY CODE AREA CODE		
Email		
Medical details		
Indicate type of condition: Acute ☐ Chronic ☐ Acute episode	of chronic L	
Please provide full details of the symptoms/medical condition requiring treatment:		
ICD9/10 code/DSM-IV		
Details of the symptoms/medical condition		
On what date did the patient first present these symptoms to you?	YYY	
On what date would the first onset of symptoms have been apparent to the patient?	YYY	
Has the patient suffered from this condition previously?	Yes□ No□	
If Yes, when?		
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□	
Please provide the Guarantee of Payment (GOP) reference number that relates to this treatment (where available)	ole):	
Applicable to cases of pregnancy only:		
Estimated date of delivery DD / MM M / YYYYY		
Is birth of a single baby expected?	Yes□ No□	
If twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction?	Yes□ No□	
If Yes, please provide further details:		

3 Your personal data

Our Data Protection Notice explains how we protect your privacy and process your personal data. You should read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html

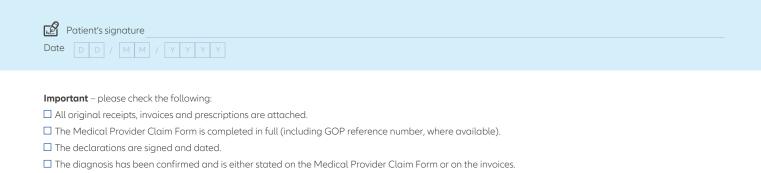
Alternatively, you can contact us on + 353 1 630 1301 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, please email us at: AP.EU1DataPrivacyOfficer@allianz.com

4 Declaration

I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information. I understand that if this claim is found to be fraudulent, in whole or in part, the contract may be cancelled from the date the fraud is discovered 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 authorise my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information about me, if requested by Allianz, to 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.



Please send the fully completed Medical Provider Claim Form(s) with original invoices attached (photocopies cannot be accepted) to the following address:

Claims Department, Allianz, 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 our Helpline on: + 353 1 630 1301 or 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