International Healthcare Plans for Lebanon

Treatment Guarantee Form

For your convenience, this form is available on our website:
www.allianzworldwidecare.com/lebanon

Treatment Guarantee is not required in advance of **emergency treatment**, however either you, your physician, one of your dependants, or a colleague need to inform us about the hospital admission **within 48 hours of the event.**

Our Helpline (**+ 353 1 630 1301**) can take Treatment Guarantee details over the telephone **if treatment is due to take place within 72 hours.** Please have as many details as possible to hand when calling, including the contact details of your doctor.

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

PLEASE COMPLETE THIS FORM IN **BLOCK CAPITALS.**

Failure to complete this form fully will delay our ability to guarantee your treatment as we may have to revert to you or the medical provider for further information.The patient's policy must be in force at the time of treatment. Please be advised that guarantee of payment is subject to the terms and conditions of the insurance policy and also subject to the assessment of all relevant documentation received, or yet to be received, by Allianz SNA or its its appointed representatives 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

Contact person *please specify who should be contacted regarding the progress of this Treatment Guarantee request*

Name

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

Telephone (Country code) (Area code)

Mobile telephone (Country code) (Network code)

Email

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.

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 dependants 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 dependants.

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 awc@allianzsna.com.

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

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 relating to me, if requested by Allianz SNA, 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 D D M M Y Y

Allianz

2 TREATMENT DETAILS *to be fully completed by the Medical Provider*

- If additional treatment is required, Allianz SNA or its appointed representatives must be notified.
- Please note that all invoices should be submitted within 60 days of patient discharge. Where special arrangements have been agreed between us and 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 Date of first attendance for this condition D D M M Y Y

On what date would the first onset of symptoms have been apparent to the patient? D D M M 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 Expected or actual date of delivery D D M M Y Y

Is birth of a single baby expected? Yes ☐ No ☐ If **No**, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes ☐ No ☐

Delivery method

Treatment

Planned procedure/treatment

Planned admission date D D M M 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 the price offered incl. currency:

If **No**, please provide a breakdown of estimated costs: Hospital charges Physician/anaesthetist fees

Total estimated costs incl. currency:

Medical provider details

Hospital/facility name

Address (including country)

Email (mandatory)

Telephone (Country code) (Area code)

Fax (mandatory) (Country code) (Area code)

Referring physician

Name

Email (mandatory)

Telephone (incl. country and area codes)

Fax (mandatory, incl. country and area codes)

Attending/admitting physician

Name

Email (mandatory)

Telephone (incl. country and area codes)

Fax (mandatory, incl. country and area codes)

Please sign 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.

Doctor's signature

Date D D M M Y Y

Official stamp of medical provider

Please send this fully completed Treatment Guarantee Form (for assistance with treatments outside Lebanon, evacuations and repatriations) at least five working days prior to treatment by:

- Scan and email to: **medical.services@allianzworldwidecare.com** or
- Fax to: **+ 353 1 653 1780** or
- Post to: Medical Services Department, Allianz Worldwide 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.

FRM-TG-Lebanon-EN-1215