

# Claim form

Please complete this form in **BLOCK CAPITALS**. You can also use our MyHealth Digital Services to submit your claim online: www.allianzcare.com/en/myhealth.html

**Don't forget:** You must submit your claims within the claiming deadline set out in your Benefit Guide, available at www.allianzcare.com/en/myhealth.html

	www.allianzcare.com/en/myhealth.html												W۱	۸W	.al	liaı	nzc	are	e.co	om	/er	n/n	nyh	nea	lth	.ht	ml	l														
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3	Please tick one of the options below and complete the details as needed.  Option 1: Payment to medical provider* (e.g. hospital, specialist) Please tick if direct billing has been previously agreed with us (The bank details requested below are not required for this option.)																																									
	Option 2:	Pay	ment	to r	nem	be	r																																			
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If you are aware of any additional information required in order to process international transactions within your country (e.g. agency code, tax ID),

If you have not already paid the medical provider.

Swift code of intermediary bank (where applicable)

\*\* For bank transfer, please provide bank details.

please list below:

- \*\*\* Cheques payable to the policyholder will be sent to the correspondence address provided in section 1.
- \*\*\*\* If your bank is within the EU, or if your specific country requires an IBAN (e.g. Qatar, Saudi Arabia, Angola, Tunisia, Turkey), please supply both your IBAN and BIC/Swift code to facilitate the payment of your claim.

### 4 Claim details

Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount charged. If your invoice/receipt does not include the diagnosis/medical condition, you must give this information below. If there is insufficient space in the table below, please provide details on a separate page.

Description of expense/ treatment	pense/ Diagnosis/medical condition										Provider's name									ency			Ha this				
																	Yes	s 🗆	No								
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Total Amount of Expenses  (Please note that the total displayed here is only accurate when all invoices are issued in the same currency.  If you are claiming costs in different currencies, please ignore the total amount displayed)																											
In what country did the treatment take place?  Has pre-authorisation been obtained?  Yes No  Applicable to cases of pregnancy only: Estimated date of delivery																											
Is birth of a single baby expected?  Yes No  If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination?  Yes No																											
If yes, please provide further details																											
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Claims related to an accident or inj If yes, please complete the following Date of accident/injury	g:	is claim	relate	d to c		ide	nt/inj	ury?		Ye	s 🔲	No [															
Details of the accident/injury																							$\perp$				
Do you have any other insurance po	olicy (e.g.	Travel i	nsurar	nce)?						Ye	s 🔲	No [															
If yes, please provide the following:																											
Name of the insurer						Ţ		Щ					<u></u>	Щ	1	Ţ		L			1	1	<u>_</u>	Ţ		L	Щ
Policy number																											
Was the accident/injury caused by a		ırty?								Ye	s 🗌 🖠	No [															
If yes, please complete the following	g:											_											_	_			
Name of the third party		11		4		4	_	Щ		<u> </u>	<u> </u>	<u> </u>	<u> </u>	Щ	4	<u> </u>	<u> </u>	<u> </u>	Ш	_	4	<u> </u>	4	<u> </u>	<u> </u>	<u> </u>	Щ
Name of the third party insurer		++				4		Щ		<u> </u>		<u> </u>	+		+	+	+	<u> </u>	Щ	_	4	_	4	+	+	<u> </u>	Щ
Third party policy number																											

Sections 5 and 6 are to be completed by the treating doctor unless the information is detailed in the supporting documentation (e.g. receipts or invoices).

Medical provider's details														
Name of doctor/specialist														
Qualifications/credentials														
Name of hospital/clinic							T							
Address														
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							Τİ		i					
Phone number COUNTRY CODE	AREA CODE						T							
Fax number COUNTRY CODE	AREA CODE							Ħ						
Email							ΤŤ		i					
Applicable to physiotherapy/psychotherapy clair	ms only. Please provide fu	II referral details												
Name of referring doctor	ns only. Flease provide ra	itt referrat details	·.											
Phone number COUNTRY CODE	AREA CODE													
	T.													
Date of referral DD / MM / YYYY	Y													
Medical details  Indicate type of treatment received: Elective   Emergency   Emergency														
ndicate type of treatment received: Elective														
ndicate type of condition: Acute  Chronic  Acute episode of chronic														
Please provide full details of the symptoms or medical condition requiring treatment:														
Please provide full details of the symptoms or medical condition requiring treatment: ICD9/10 code/DSM-IV														
Details of the symptoms/medical condition														
On what date did the patient first present these s	ymptoms to you?		D D / M M	/ Y Y	YY									
On what date would the first onset of symptoms I	nave been apparent to the	e patient?	D D / M M	/ Y Y	YY									
Has the patient suffered from this condition previ	ously?			Yes □	No□									
If Yes, when?			D D / M M	/ Y Y	YY									
Are you aware of any treatment given for this or	any related illness in the p	ast?		Yes 🗆	No□									
If Yes, please provide details														
				İ										
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 🗆										
Applicable to dental treatment claims only:														
Was the patient suffering from dental pain at the	time he/she visited you fo	or treatment?		Yes □	No									
was the patient surrering from dental pain at the	time negatic visited you're	or treatment.		103 🗀	110									
Please sign and authenticate with an official star	np.													
	0	Official sta	amp of r	nedico	l provid	der								
Doctor's signature														
Date DD / MM / Y Y Y Y														

## 7 We care about your personal data protection

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6

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:

AP.EU1DataPrivacyOfficer@allianz.com

#### 8 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 will 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 Care, 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.

Patient's signature

### 9 We need your consent

In line with the General Data Protection Regulation (GDPR), we need your 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 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.

#### 10 Third party authorisation

As the claimant, I authorise

INCEDT NAME OF THIRD DARTS

to act on my behalf in relation to the administration of this claim. This may include the disclosure of sensitive medical information.

Claimant's signature																						
Claimant's printed name																						
Date	D	D /	М	М	/ [	Υ	Υ	Y														

It is your responsibility to retain any original supporting documents (e.g. medical receipts) when you send us copies, as we reserve the right to request original supporting documents up to 12 months after each claim has been settled, for auditing purposes. We also reserve the right to request a proof of your payment (e.g. bank or credit card statement) in respect of your medical receipts. We advise you to 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.

## Please send your fully completed Claim Form(s) with invoices/receipts by:

© Email to: claims@allianzworldwidecare.com

Post to: Claims Department, Allianz Care, 15 Joyce Way, Park West Business Campus,

Nangor Road, Dublin 12, Ireland

#### Important – please check the following:

- All receipts, invoices and prescriptions are attached
- The Claim Form is completed in full.
- The declarations are signed and dated.
- The diagnosis has been confirmed and is stated either on the Claim Form or on the invoices.
- If you have changed your contact details, please let us know on the Claim Form

#### Did you know...

...that most of our members find that their queries are handled quicker when they call us?

If you have any queries, please contact our Helpline: 8000 155 (calling toll-free from within Qatar)

+974 4031 8444 (calling from within or outside of Qatar)

client.services@e.allianz.com

For our latest list of toll-free numbers, please visit: www.allianzcare.com/toll-free-numbers