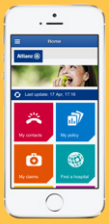
MyHealth app for quick and easy claims submission



www.allianzworldwidecare.com/myhealth

Allianz Worldwide Care Services acting on behalf of Allianz Private Krankenversicherungs-AG

Group Claim Form

For your convenience, this form (editable PDF version) is available on our website: www.allianzworldwidecare.com/pkv.
If you choose to complete this form in handwriting please use **BLOCK CAPITALS**.

1 Policyholder's details

Policy Number | Date of birth D D / M M / Y Y

First name

Surname

Latest correspondence address

Telephone number COUNTRY CODE AREA CODE

Email

Do you have any national/public or state provided health insurance cover in your home country or country of residence e.g. National Health Insurance? Yes ☐ No ☐

If Yes, please provide a description of the cover provided along with your reference number/identifier with the state.

2 Patient's details (if different from policyholder)

First name

Surname

Date of birth D D / M M / Y Y Gender: Male ☐ Female ☐

3 Payment details

Option 1: Payment to medical provider* (e.g. hospital, specialist) ☐ *(The bank details requested below are not required for this option)*

Option 2: Payment to policyholder ☐

Preferred payment method: Bank transfer** ☐ Cheque*** ☐

Please **specify the currency** you would like to be **reimbursed** in (and ensure that your bank account supports it)

Name of bank account holder as shown on your bank statement

Account number

IBAN (where required)****

Sort/branch code | BIC/Swift code****

Name of bank

Bank address

If you are aware of any additional information required in order to process international transactions within your country (e.g. Agency Code, Tax ID), please list below:

Swift code of intermediary bank (where applicable)

** If you have not already paid the medical provider.*
*** For bank transfer, please provide bank details.*
**** 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.*

Allianz

4 Claim details

Please complete all parts of the following table with the details of each invoice/receipt. Please note that for costs incurred in China, a FaPiao invoice needs to be submitted with all claims. If your invoice/receipt does not include the diagnosis/medical condition, please ensure that you provide us with this information below. If there is insufficient space in the table below, please provide details on a separate page.

Description of expense/treatment	Diagnosis/medical condition	Provider's name	Amount charged/ currency	Has this bill been paid by you?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

In what country did the treatment take place?

Applicable to cases of pregnancy only: Estimated date of delivery D D / M M / Y Y

If this claim is resulting from an accident or work-related illness/injury and you hold any other insurance policy (e.g. car insurance), or if you are filing a claim or lawsuit against a third party to recover the costs incurred as a result of this accident/injury, please provide details in a separate document.

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

5 Medical provider's details

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Telephone number COUNTRY CODE AREA CODE

Fax number COUNTRY CODE AREA CODE

Email

Applicable to **physiotherapy/psychotherapy** claims only. Please provide full referral details:

Name of referring physician

Telephone number COUNTRY CODE AREA CODE Date of referral D D / M M / Y Y

6 Medical details

Indicate type of condition: Acute ☐ Chronic ☐ Acute episode of chronic ☐

Please provide full details of the symptoms/medical condition requiring treatment, including ICD9/10 code/DSM-IV

On what date did the patient first **present** these symptoms **to you**? 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

Official stamp of medical provider

Please sign and authenticate with an official stamp.

Doctor's signature

Date D D / M M / Y Y

It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claims settlement for auditing purposes. We also reserve the right to request a proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. 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.

Please send your fully completed Claim Form(s) with invoices/receipts as follows:

By email to: pkv.claims@allianzworldwidecare.com

By fax to: + 353 1 645 4033

By post to: Claims Department, Allianz Worldwide Care Services, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.