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

Treatment Guarantee 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.

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

Section 2 must be fully completed by the doctor

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 1 514 8456****) 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.*

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 Worldwide Care Services 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

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

- If additional treatment is required, Allianz Worldwide Care Services 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

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

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, 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

Please send this fully completed Treatment Guarantee Form at least five working days prior to treatment by:

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