Medical Claim Form

The following notes have been prepared to assist you with your claim. Please read them carefully BEFORE you complete this form. Please note that we are not responsible for any fees that you may incur for completion of this form. The issue of this Claim Form is in no way representative of an admission of liability.

For ongoing claims please complete a Continuation of Claim Form and enter the name of the medical condition and settlement number of your previous claim.

To help us process your claim please follow the guidelines below:

- Please check your policy to ensure that you are covered for the expenses you are claiming. If you are unsure what your policy covers, please call our helpline +353 1 629 7140
- A separate Claim Form must be completed for each patient and each new medical condition being claimed
- Please complete all sections in full using BLOCK CAPITALS
- Sections A to E should be completed by the member/claimant
- Sections F to G should be completed by the attending Medical Practitioner/Specialist
- ALL RELEVANT ORIGINAL INVOICES MUST BE ATTACHED TO THE CLAIM FORM. Photocopies, receipts and credit card slips will not be accepted. We recommend that you keep copies of all documents submitted
- Any additional documents and materials that we require to support your Claim shall be provided at your own expense

Please send your fully completed Claim Form(s) with original invoices to the following address:

ALC Health Claims
Allianz Worldwide Care Ltd
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

Helpline

T + 353 1 629 7140

F + 353 1 630 1306

E claims@alchealth.com

Allianz Worldwide Care Limited underwrite the risk and administer claims on behalf of à la carte healthcare limited.

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aLC
GLOBAL HEALTH INSURANCE

Medical claim details

Section A - Policyholder's details

Policy Number

First Name

Surname

Date of birth (dd/mm/yyyy)

Correspondence Address

Postcode

Country

Telephone number (day time)

Telephone number (evening)

Fax

Email

Section B - Patient's details

Is the patient/claimant the policyholder stated above? Yes No

If you are NOT the policyholder, please complete this section

First name

Surname

Date of birth (dd/mm/yyyy)

Section C - Payment details

Option 1: Payment to Medical Provider (e.g. Hospital, Specialist)

Please tick if direct billing has previously been agreed with the ALC Health claims team

Option 2: Payment to Policyholder

Preferred payment method: Cheque* Bank transfer**

*Cheques payable to policyholders will be sent to the correspondence address provided in Section A

** For Bank Transfers, please provide bank details below

Name of bank account

Payment to be made in: Invoice currency Yes No Other currency (Please specify)

Account number

Sort/branch code

Name of Bank

Bank address

Postcode

IBAN (EU only)

BIC/Swift Code (EU only)

Section D - Claim details

Is the claim in relation to an

Injury ☐ if yes, please complete questions **1-6**

Illness ☐ if yes, please complete questions **3-6**

1. Do you hold any other insurance policy e.g. car insurance, which provides you with cover in relation to this accident/injury? Yes ☐ No ☐

If yes, please provide details of the insurer and the policy number

2. Are you filing a claim or lawsuit against a third party, including an insurance company, to recover costs incurred as a result of this accident/injury? Yes ☐ No ☐

If yes, please provide the details of third party concerned

3. Please provide full details on nature of injury or full details of medical condition, illness or symptoms

4. Is this the first time you have sought treatment for this Illness/Injury? Yes ☐ No ☐

If no please provide details

5. In which country did treatment take place?

6. Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount and currency

Description of expense	Provider's name	Amount charged	Currency	Has this bill been paid by you?

Section E – Patient signature and release of medical records

I certify that to the best of my knowledge this Claim Form does not contain any false or misleading information. I understand that, in the event that this Claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution. In respect of any Medical Claim, I hereby authorise my Medical Practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by ALC, Allianz Worldwide Care or their appointed representatives.

If a minor (under 18 years) was treated, a Parent or Guardian should sign this section.

Patient's signature

Date (dd/mm/yyyy)

Sections F and G should be completed by the treating Medical Practitioner/Specialist in BLOCK CAPITALS unless your Invoices or Medical Report contain details of the diagnosis as well as the nature of your treatment and the exact date of onset of symptoms.

Section F - Medical provider's details

Name of Medical Practitioner/Specialist

Qualifications/credentials

Name of Hospital/Clinic

Address

Country | Postcode

Telephone Number | Email

Applicable to Physiotherapy or Complementary Treatment. Please provide full referral details.

Name of referring Physician

Telephone Number | Date of Referral (dd/mm/yyyy)

Section G - Medical details

Are you the patient's usual Medical Practitioner or Specialist? Yes ☐ No ☐

If yes, for how long?

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

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

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

On what date would the first onset of symptoms have been apparent to the patient?

Has the patient suffered from this condition previously? Yes ☐ No ☐

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 ☐

Does it continue indefinitely or have no known cure? Yes ☐ No ☐

If patient requires a stay in hospital please advise number of nights and dates, if known.

Number of nights | Date from | Date to

Pregnancy:

Date of LMP (dd/mm/yyyy)

Date of pregnancy confirmed by a Medical Practitioner (dd/mm/yyyy)

Estimated date of delivery (dd/mm/yyyy)

Please sign and authenticate with an official stamp

Medical Practitioner or Specialist signature

Official Stamp

Date (dd/mm/yyyy)