Treatment Request Form

Please read the following carefully, completing all relevant information in BLOCK CAPITALS and ticking (✓) the relevant boxes

Is this an extension to an existing Treatment Request Yes ☐ No ☐

If 'Yes', please provide the Treatment Request ID reference number

Important information – please read carefully

To help us process the direct settlement of your medical expenses as soon as possible, please follow the guidelines below. If you have any questions, please contact **our Helpline on +353 1 629 7140.**

To the patient:
Please ensure that you complete sections 1, 2 and 3 and that your Medical Provider and Doctor completes all questions in sections 4 and 5. Failure to complete this form fully will delay our ability to guarantee your treatment as we may have to contact 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 medical assessment of all relevant documentation received, or yet to be received, by Allianz Worldwide Care in respect of this medical condition.

Please send the Treatment Request Form to Allianz Worldwide Care 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: à la carte healthcare claims, Medical Services Department, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

Treatment Request 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 24 hours of the event**.

Please note that the Helpline can accept Treatment Requests over the phone if treatment is due to take place **within 72 hours**. Please have as many details as possible ready to give over the phone, including the contact details of your doctor.

Section 1 – Patient Details

To be fully completed by (or on behalf of) the patient.

Policy Number

First Name

Surname

Date of birth (dd/mm/yyyy)

Section 2 – Contact Details

Please specify who should be contacted regarding the progress of this Treatment Request.

Contact 1

Name

Relationship to patient eg self, spouse/partner, parent

Telephone Number (day time)

Telephone number (evening)

Fax (including country code)

Email

Contact 2 (optional)

Name

Relationship to patient eg self, spouse/partner, parent

Telephone Number (day time)

Telephone number (evening)

Fax (including country code)

Email

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Section 3 – Patient signature and release of medical records

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 Health, 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)

To the Medical Provider:

If additional treatment is required, Allianz Worldwide Care must be notified.

The hospital should submit this Treatment Request Form and the corresponding invoices to Allianz Worldwide Care within 30 days of patient discharge.

If invoices are received more than 60 days after patient discharge, acceptance of liability for those expenses remains at the discretion of Allianz Worldwide Care.

Section 4 – Medical certificate – to be completed by the Medical Provider

To be fully completed by the medical provider

Please tick the relevant treatment category:

Medical ☐ Maternity ☐ Psychiatry ☐ Oncology ☐ Rehabilitation ☐

For in-patient/day-patient treatment:

Planned admission date (dd/mm/yyyy)

For treatment in Germany (DRG) please confirm Base Price ("Basisfallpreis")

Is a package price being offered? Yes ☐ No ☐

If 'no', please provide a breakdown of estimated costs including currency:

Hospital charges

Surgeon/physician fees

Anaesthetist fees

Hospital/facility name

Address

Country

Telephone number (including country code)

Fax (including country code) Email

Estimated length of stay Number of Days Number of Nights

Details of attending/admitting physician:

Name

Telephone number (including country code)

Fax (including country code) Email

Date of first attendance for this condition? (dd/mm/yyyy)

Date this condition was first diagnosed? (dd/mm/yyyy)

On what date would the first onset of symptoms have been apparent to the patient? (dd/mm/yyyy)

Section 5 – to be completed by the Treating Doctor

Details of referring physician:

Name

Telephone number (including country code)

Fax (including country code)

Email

Date of referral (dd/mm/yyyy)

Diagnosis:

Please provide ICD 9/ICD 10/DSM IV/DRG/other diagnosis code and a full description

ISD 9/ICD 10

DSM IV

DRG

Other code

Description

Please provide details of any current medication the patient is taking

Planned procedure /treatment:

For treatment in the USA/UK, please provide CPT/CCSD code(s) and a full description.

CPT code(s)

CCSD code(s)

Description

Maternity:

Date pregnancy confirmed by doctor (dd/mm/yyyy)

Expected or actual date of delivery (dd/mm/yyyy)

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 ☐

Please sign and authenticate with an official stamp

Doctor's signature

Date (dd/mm/yyyy)

The confidentiality of patient and member information is of paramount concern to Allianz Worldwide Care. Allianz Worldwide Care fully complies with European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access ther personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is accurate or out of date.

Official stamp of medical provider

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