

Claim Form

To help us provide you with a fast and efficient service, we kindly ask you to note the following:

- A fully completed form will speed up the assessment and payment of your claim
- Please complete the front page of this form and ask your treating doctor to complete the back page.
- All relevant original invoices must be attached. Unfortunately, photocopies, receipts and credit card slips cannot be accepted.
- If you are submitting invoices from Germany or the USA, or if your invoices contain details of diagnoses as well as the nature of your treatment, there is no need to complete the reverse side of this form., simply attach the original invoices.
- A separate claim form is required for every patient and each medical condition.
- We recommend that you keep copies of all documents submitted, should you require them at a later date.
- Finally we kindly ask that you complete this form in **BLOCK CAPITALS**, and post to the address below.

1. Policyholders Details

Insurance Number	<input type="text"/>	Title	<input type="text"/>
Surname	<input type="text"/>	First Name(s)	<input type="text"/>
Correspondence address	<input type="text"/>		
Phone No. Daytime	<input type="text"/>	Evening	<input type="text"/>
Fax	<input type="text"/>	E-mail	<input type="text"/>

2. Patients Details

Title	<input type="text"/>	Surname	<input type="text"/>	First name(s)	<input type="text"/>					
Date of Birth (dd/mm/yy)	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	Is this claim related to an accident ?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

3. Payment Details

Option 1 Payment to Policyholder/Insured

Payment to be made in:	Invoice currency	<input type="text"/>	Other currency (Please specify)	<input type="text"/>
Preferred payment method	Cheque	<input type="checkbox"/>	Bank Transfer (please complete bank details below)	<input type="checkbox"/>
Name of bank account	<input type="text"/>			
Account no. / IBAN	<input type="text"/>	Sort/branch code	<input type="text"/>	
Swift Code	<input type="text"/>	Bank Name	<input type="text"/>	
Bank Address	<input type="text"/>			

Option 2 Payment to Provider of Medical Services (e.g. Hospital, Specialist, MRI)

Please tick if Direct Billing has been previously agreed with Allianz Worldwide Care

4. Patient Signature and Release

I certify that to the best of my knowledge, this claim form does not contain any false, misleading or incomplete 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 general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Allianz Worldwide Care Limited or their appointed representatives.

If a minor was treated, a parent or guardian should sign this section.

Patient signature	<input type="text"/>	Date (dd/mm/yy)	<input type="text"/>
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TO BE COMPLETED BY THE TREATING DOCTOR IN **BLOCK CAPITALS.**

5. Medical Provider Information

Name of doctor/specialist 医師名

Qualifications/credentials 資格

Name of hospital/clinic 病院名

Address 住所

Phone 電話番号

Fax 番号

Email メール

6. Medical Information

Has Treatment Guarantee been obtained ?
治療保障を受け取りましたか。

Yes
はい

No
いいえ

Indicate type of treatment received ?
どちらの治療を受けましたか。

Elective
通常来院

Emergency
緊急来院

Indicate type of condition
どのように発病しましたか。

Acute
急性

Chronic
慢性

Acute episode of a
chronic condition
習慣的発病

Please provide full details of the medical condition requiring treatment, including ICD code/DSM-IV
病名又はコード番号

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On what date did the patient first present these symptoms to you ?
最初に来院した日。

Date (dd/mm/yy)
日付 (日/月/年)

/	/
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Prior to consulting you, when did the patient first notice signs or
symptoms of this medical condition ?
最初に症状がでた日。

Date (dd/mm/yy)
日付 (日/月/年)

/	/
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Are you aware of any treatment given for this or any related illness in the past ?
以前、同じところを治療したことがありますか。

Yes
はい

No
いいえ

If Yes, please give details
はいの場合、詳細を記入してください。

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

Applicable to dental treatment only
歯科医師のみ

Was the patient suffering from dental pain at the time he/she visited you for treatment ?
患者が来院したとき、痛みを訴えていましたか。

Yes
はい

No
いいえ

Doctors Signature
医師のサイン

Date (dd/mm/yy)
日付 (日/月/年)

STAMP

The confidentiality of patient and member information is of paramount concern to Allianz Worldwide Care. Allianz Worldwide Care fully complies with the European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the 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 inaccurate or out of date.