Allianz
Allianz Worldwide Care

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 the 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.

Policyholder Details

Insurance number ______ Title ______

Surname ______ First name(s) ______

Correspondence address ______

______

Phone no. daytime ______ Evening ______

Fax ______ E-mail ______

Patient Details

Title ______ Surname ______ First name(s) ______

Date of birth (dd/mm/yy) __/__/__ Is this claim related to an accident? Yes ☐ No ☐

Payment Details

Option 1 Payment to **Policyholder/Insured** ☐

Payment to be made in: Invoice currency ☐ Other currency (please specify) ______

Preferred payment method: Cheque ☐ Bank transfer ☐ (please fill in bank details)

Name of bank account ______

Account no./IBAN ______ Sort/branch code ______

Swift code ______ Bank name ______

Bank address ______

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

Please tick if direct billing has been previously agreed with Allianz Worldwide Care ☑

Patient Signature & 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 ______ Date (dd/mm/yy) __/__/__

Allianz Worldwide Care Limited, Claims Department,
20D Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.
Helpline +353 1 630 1301 Fax +353 1 630 1306 E-mail client.services@allianzworldwidecare.com

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To be completed by treating doctor in block capitals

Medical Provider Information

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Phone Fax

E-mail

Medical Information

Has Treatment Guarantee been obtained? Yes ☐ No ☐

Indicate type of treatment received: Elective ☐ Emergency ☐

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

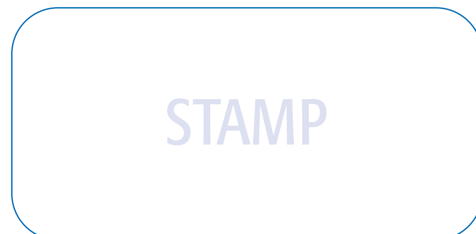
On what date did the patient first present these symptoms to you? Date (dd/mm/yy) / /

Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition? Date (dd/mm/yy) / /

Are you aware of any treatment given for this or any related illness in the past? Yes ☐ No ☐
If yes, please provide details

Applicable to dental treatment only.
Was the patient suffering from dental pain at the time he/she visited you for treatment? Yes ☐ No ☐

Doctor signature Date (dd/mm/yy) / /



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 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.