

Treatment Guarantee Form

Please complete this form in **BLOCK CAPITALS.**

Treatment Guarantee is not required in advance of emergency treatment. However either you, your physician, one of your dependants, or a colleague must inform us about your admission to hospital within 48 hours of the event.

Our Helpline (+ 353 1 630 1301) can take Treatment Guarantee details over the telephone if treatment is due to take place within 72 hours. Please have as much information as possible to hand when calling, including the contact details of your doctor.

Section 1

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

Section 2

must be fully completed by the doctor

Failure to complete this form in full will delay us in guaranteeing your treatment because 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 note that guarantee of payment is subject to the terms and conditions of the insurance policy. It is also subject to our assessment of all the relevant documentation we need in respect of this medical condition.

Patient a	details	to be fully	completed by	(or on b	ehalf of	the natient
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Policy number																				
First name																				
Surname																				
Date of birth	D D / M M / Y	YYY																		
Contact person: please specify who we should contact regarding the progress of this Treatment Guarantee request																				
Contact person:	please specify who we sl	hould contac	ct regar	dina t	he p	roare	ss of t	his Tr	eatme	ent Gu	ıaran	tee r	eaue	est						
Contact person:	please specify who we sl	hould conta	ct regar	ding t	he p	rogre	ss of t	this Tr	eatme	ent Gu	ıaran	tee r	eque	est						
Contact person: Name	please specify who we sl	hould conta	ct regar	ding t	he p	rogre	ss of t	this Tr	eatme	ent Gu	Jaran	tee r	eque	est						
Name	please specify who we sl		ct regar	ding t	he p	rogre	ss of t	this Tr	eatme	ent Gu	uaran	tee r	eque	est						
Name				code	he p	rogre	ss of t	this Tr	eatme	ent Gu	uaran	tee r	eque	est						
Name Relationship to p	patient (e.g. self, spouse/partn			CODE		rogre	ss of t	this Tr	eatme	ent Gu	uaran	tee r	eque	est						

We care about your personal data protection

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html

Alternatively, you can contact us on +35316301301 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by email at: AP.EU1DataPrivacyOfficer@allianz.com

I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorise my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information about me, if requested by Allianz Care, its medical advisers or its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply.

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



We need your consent

In line with the General Data Protection Regulation (GDPR), we need your consent to process your medical information and pay your medical expenses. If you haven't provided us with your consent, please access https://my.allianzcare.com/myhealth/login, login to MyHealth Digital Services and tick the required fields. Alternatively, you can download the Consent Form from www.allianzcare.com/en/consent-form. A paper copy is available on request. Please note that every member on the policy over 18 must provide their own consent.

2 Treatment details to be fully completed by the medical provider.

- If additional treatment is required, Allianz Care must be notified.
- Please note that all invoices should be submitted within 60 days of patient discharge. However, where we have agreed special arrangements with 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 Y							
Date of first attendance for this condition		D D / M M / Y Y Y							
On what date would the first onset of sympto	ms have been apparent to the patient?	D D / M M / Y Y Y Y							
Diagnosis (if unknown, please state provisional diagn	osis)								
ICD9/10 DSM-IV	DRG DRG								
Treatment									
Planned procedure/treatment									
Planned admission date DD / MM M	/								
For treatment in the UK									
CPT code(s)	CCSD code(s)								
Description									
Costs									
Estimated length of stay	$night(s) \square / day(s) \square$ (tick as appropriate)								
Is a package price being offered? Yes \square	No □"								
If Yes, please state price offered incl. currency	/								
If No, please provide a breakdown of estimat	red costs:								
Hospital charges	Doctor/anaesthetist fees	Total estimated costs incl. currency:							
Medical provider details									
Hospital/facility name									
Address (including country)									
Email (mandatory)									
Telephone (incl. country and area codes)									
Fax (mandatory, incl. country and area codes)									
Tax (mandatory, inct. country and area codes)	Defenda a de stan	Association of a desiration or desirate							
N.	Referring doctor	Attending/admitting doctor							
Name									
Email (mandatory)									
Telephone (incl. country and area codes)									
Fax (incl. country and area codes)									
Please sign, date and authenticate with an I confirm that all the details given in this form		occurate and complete Official stamp of medical provider							
restanting at the details givernin tills form	are, to the best of my knowledge, thee, di	courace and complete.							
Doctor's signature									
Date DD / MM / Y Y Y Y									

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Please send this fully completed Treatment Guarantee Form along with all supporting documentation at least five working days before treatment by email to: apple.helpline@e.allianz.com

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.

If you have any queries please contact us:

Helpline: + 353 1 630 1301 or email: apple.helpline@e.allianz.com

 $For our latest \ list of toll-free numbers, please \ visit: {\bf www.allianzcare.com/en/pages/toll-free-numbers.html}$

To facilitate your pre-approval request, please ensure to submit all required documentation:

Dedicated member hub: www.allianzcare.com/en/group-hub/Apple.html