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.

Are you covered? Where to send the claim form

It is important to check your policy to make sure that you are covered for the expenses for which you are claiming. If you are in any doubt as to what your policy covers, please feel free to contact our Helpline staff on:

T + 353 1 629 7140

Calls may be recorded or monitored for quality and training purposes.

F + 353 1 630 1306

E claims@alchealth.com

All claims correspondence should be sent to:

à la carte healthcare claims
Allianz Worldwide Care Ltd
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

Direct payment of In-patient/Day-patient medical costs

You are requested to contact us at least **FIVE DAYS** prior to planned hospital admissions so that we can communicate with the hospital to facilitate smooth admission and guarantee direct payment. **Please note that without sufficient notice and the necessary medical information, we cannot guarantee that we will be able to arrange direct payment.**

Completing the form

- A **fully completed form** will allow us to make an efficient assessment and prompt payment of your claim.
- Please complete Sections A, B, C and D and ask your Doctor or Consultant (as appropriate) to complete and sign Section E - the Medical Certificate. If the Medical Certificate and/or Declaration is not completed or signed, the claim cannot be processed.
- **Please attach all original invoices.** Photocopies, receipts and credit card slips cannot be accepted.
- A separate Claim Form is required for each patient and each medical condition.
- If claiming for Cash Benefit, a certificate from the hospital confirming the number of nights in-patient stay is required.
- We recommend that you keep copies of all documents submitted, should you require them at a later date.
- All documents and materials (including but not limited to original accounts, certificates and X-rays) that we require to support a claim shall be provided without expense to us (including if requested by us a medical report from the insured person's Medical Practitioner or Specialist and details of the insured person's medical history prior to any claim). In cases where medical information is required by us for consideration of a claim but it is not available to us, it is the responsibility of the insured person to obtain such information from the current or previous Medical Practitioner as appropriate.
- If your Claim Form has been altered in any way, your claim may be rejected.

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

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Registered in England no 4163178. Registered Office: A2 Yeoman Gate Yeoman Way Worthing West Sussex BN13 3QZ United Kingdom à la carte healthcare limited is authorised and regulated by the Financial Services Authority

Medical claim details

Section A - Policyholder & claimant details

Name of Policyholder (as shown on the Certificate of Insurance)

Policy Number

Name of Group (if applicable)

Name of claimant

Correspondence Address

Postcode

Country

Date of birth (dd/mm/yyyy)

Gender Male Female

Telephone Number

Fax Number

Email Address

Section B - Claim details

If Injury:

Please provide full details of nature of injury

Date when injury occurred (dd/mm/yyyy)

Where did injury occur?

Please provided details/circumstances of how injury was caused

Was a third party responsible for the injury? Yes No

If yes, please provide the following on a separate sheet: Incident details, Third party details, Third party Insurance Details

If Illness:

Please provide full details of medical condition/illness requiring treatment

Date when symptoms were first noticed for this occurrence of the illness (dd/mm/yyyy)

Describe symptoms

Date when you first sought medical attention for this occurrence (dd/mm/yyyy)

In which country did you first seek treatment for this condition?

Have you suffered from this condition previously? Yes No

If yes, please provide full details including dates

If Pregnancy: Please state:

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

If you have given birth, were there complications? Yes No

If you suffered complications in pregnancy or childbirth please provide details

All Claimants:

Have you previously made a claim under this policy for this condition? Yes ☐ No ☐

If yes, please provide full details

If you were hospitalised or are due to be hospitalised for this condition, please provide full details including dates

Name and address of hospital (including country)

Name and address of attending Medical Practitioner in hospital (if different from above)

Please provide the name and address of your usual General Practitioner

Did you contact the Claims Information and Helpline? Yes ☐ No ☐

Do you hold any other insurance under which this claim may be considered? Yes ☐ No ☐
If yes, please provide details (including Insurance details) on a separate sheet.

Section C - Amount claimed (continue on a separate sheet if necessary)

Description of expense: For example, Provider's name, prescription charges, X-ray etc	Amount charged (please specify the currency)	Has this bill been paid by you? YES/NO
Total amount (please specify currency)		

Please note the following:
Where a currency conversion is required the rate will be that prevailing at the date of the invoice.

Payment Details:

Payment to Policyholder ☐ Payment to 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

Postcode

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

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

Please tick if direct billing has been previously agreed with a la carte healthcare claims ☐

Section D – Declaration

I declare that to the best of my knowledge all particulars contained in this form are true. I hereby give my permission for any Doctor, Consultant or other authority mentioned herein to release further information regarding my Medical records to à la carte healthcare limited and their appointed administrators. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Reports Act (AMRA) or other similar legislation. 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.

Data Protection Act

The Insurance Industry operates a number of anti fraud initiatives. The information on this form may be stored electronically and we may release certain information to other insurers or other interested parties. All data is maintained in accordance with the provisions of the Data Protection Act.

Signed (Policyholder/Claimant)

Date (dd/mm/yyyy)

(If patient is under 18 years, parent or guardian must sign)

Section E - Medical Certificate

To be completed by the attending Medical Practitioner or, where possible, the Patient's usual General Practitioner.
Any fee for completion of this form is the responsibility of the Policyholder/Claimant.

Full Name of Patient

Date of birth (dd/mm/yyyy) Gender Male Female

Are you the patient's usual doctor? Yes No If yes, for how long?

Please provide full details of:

The medical condition requiring treatment

Any medication prescribed

Any treatment required or administered

The likely period of treatment

Results of any investigations, pathology performed or to be performed

Has patient been referred to a Specialist or Hospital? Yes No

If yes, please provide full details and advise nature of surgery or treatment with date(s) such procedure(s) to be carried out.

Number of nights patient was hospitalised

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

How long prior to this date would the condition or symptoms been apparent to the patient?

Date when symptoms were first noted by patient (dd/mm/yyyy)

Date when first sought medical attention (dd/mm/yyyy)

Date present condition first diagnosed (dd/mm/yyyy)

Has the patient ever been treated for this condition or associated complaint before? Yes No

If yes, please provide full details and dates

Does the condition continue indefinitely and have no known cure? Yes No

Does it come back or is it likely to come back? Yes No

Is it permanent? Yes No

Does it need rehabilitation? Yes No

Does it need long term monitoring, consultations, check ups, examinations or tests? Yes No

Please provide any relevant information

Pregnancy

If the claim concerns pregnancy, please state: Date of LMP (dd/mm/yyyy)

Date pregnancy confirmed by a Doctor (dd/mm/yyyy)

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

If your patient has given birth, were there complications? Yes No

If yes, please provide details

Declaration

To be completed by the attending Medical Practitioner or the patients usual General Practitioner/Optometrist or Ophthalmologist

Name Qualifications

Address

Postcode

Telephone Number Fax Number

Signature

Official Stamp

Date (dd/mm/yyyy)

D GEN/MCF/07/09