...peace of mind for whatever is beyond your horizon

Routine Health Management 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

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

Amount claimed (continue on a separate sheet if necessary)

Description of Expense	Amount charged (please specify the currency)	Date of Test/Treatment (dd/mm/yyyy)	Date of last Test (dd/mm/yyyy)
1) Hearing Test carried out by a medical practitioner			
2) Routine Health Check			
3) Well child test			
4) Vaccinations			
Total amount (please specify currency)			

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

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GLOBAL HEALTH INSURANCE

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 ____

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 Medical Practitioner/General Practitioner/Nurse/Optometrist or Ophthalmologist, or other authority mentioned herein to release further information regarding my Dental 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)

Medical Certificate

To be completed by the attending Medical Practitioner/General Practitioner/Nurse. Any fee for completion of this form is the responsibility of the Policyholder/Claimant.

Hearing Test
Details of Tests carried out ____

Routine Health Check
Details of Tests carried out ____

Well Child Test - details of tests carried out ____

Vaccinations
Details of immunisations or booster injections ____

Were they required under regulation of the country in which treatment is being given? Yes ☐ No ☐

Details of travel vaccinations or malaria prophylaxis ____

Name and address of examining Medical Practitioner or General Practitioner or Other ____

Postcode ____

Signature ____ Official Stamp

Date (dd/mm/yyyy) ____

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