Treatment Guarantee

1. Insured Section - all sections to be fully completed by the insured member/patient

Name of patient _____ Date of birth ☐☐ ☐☐ ☐☐
d d m m y y

Insurance number _____

Phone number *Home* _____ Phone number *Business* _____

Fax number *Home* _____ Fax number *Business* _____

E-mail *Home* _____ E-mail *Business* _____

2. Provider Section - all sections to be fully completed by the medical provider

Hospital/Facility (incl. address) _____

_____

_____

Name of attending/admitting Physician _____

Admission type ☐ Inpatient ☐ Outpatient ☐ Dental

Diagnosis (ICD-10 or any other code if available, otherwise a full description) _____

_____

_____

Planned procedure **with** medical justification _____

_____

_____

For In-patient:

1. Planned admission date _____ 2. Estimated Cost _____ 3. Estimated length of stay _____

3. Insurance Information (This section to be completed by Allianz Worldwide Care)

Treatment Guarantee Number _____

Type of Room _____ Deductible _____

Maximum Annual Allowance _____ Co-payment due _____

Exclusions: Personal items (flowers, telephone calls, extra meals, etc.,)

Patient Contribution _____ Allianz Worldwide Care Contribution _____

For billing, please submit an Itemised Bill and an Allianz Worldwide Care Claim Form to the address overleaf.

Signed for and on behalf of Allianz Worldwide Care Ltd.:

Agent's Signature _____

Release of Medical Records

I authorize all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to release my medical records to Allianz Worldwide Care.

Signature of the Patient, (or Employee/Subscriber if Patient is under 16) Date

Guidelines

To the insured member/patient

In order to ensure swift guarantee of your treatment, please complete all questions in the Insured Section. Please also ensure that your doctor completes all questions in the Provider Section.

Failure to complete this form could delay our ability to guarantee your treatment with the medical provider, as we may have to revert to you for further information.

To the medical provider

Please note that the patient is insured by Allianz Worldwide Care Ltd. We guarantee payment of the expenses specified in this Treatment Guarantee form in accordance with the following conditions:

a) The hospital will undertake the specified procedures within 7 days of the date of this guarantee.

b) If additional treatment is required, Allianz Worldwide Care must be notified.

c) The hospital should submit the Claim Form and the corresponding invoices to Allianz Worldwide Care within 30 days of patient discharge.

d) Allianz Worldwide Care will settle the guaranteed expenses within 30 days of receipt.

e) If invoices are received more than sixty days after patient discharge, acceptance of liability for those expenses remains at the discretion of Allianz Worldwide Care.

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