Allianz Care

Pre-authorisation Form

Pre-authorisation is not required in advance of **emergency treatment**. However either you, your doctor, one of your dependants or a colleague must inform us about your admission to hospital **within 48 hours of the event**.

Our Helpline can take Pre-authorisation details over the phone **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.

Guidelines on how to complete this form:

If you are using a printed version of this form, please complete it in **BLOCK CAPITALS**.

Section 1 must be fully completed by (or on behalf of) the patient.

Section 2 must be fully completed by the doctor.

Please note that:

- 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.
- The 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.

1 Patient details - To be fully completed by (or on behalf of) the patient

Policy number

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other

First name

Surname

Date of birth D D / M M / Y Y Y Y

Contact person: please specify who we should contact regarding the progress of this Pre-authorisation request

Name

Relationship to patient (e.g. self, spouse/partner, parent)

Phone COUNTRY CODE AREA CODE

Mobile Phone COUNTRY CODE AREA CODE

Email

Talent Trust

Your personal data

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 **+ 353 1 630 1301** 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.

Patient's signature _____

Date D D / M M / Y Y Y Y

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 **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, you need to notify Allianz Care.

Please note that all invoices must 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 Y

Date of first attendance for this condition D D / M M / Y Y Y Y

On what date would the first onset of symptoms have been apparent to the patient? D D / M M / Y Y Y Y

Diagnosis (if unknown, please state provisional diagnosis)

ICD9/10 DSM-IV DRG

Please also provide the following details for maternity cases

Date pregnancy confirmed by doctor D D / M M / Y Y Y Y

Expected or actual date of delivery D D / M M / Y Y Y Y

Is birth of a single baby expected? Yes ☐ No ☐

If No, is the pregnancy a result of medically assisted reproduction? Yes ☐ No ☐

Delivery method

Treatment

Planned procedure/treatment

Planned admission date D D / M M / Y Y Y Y

For treatment in the USA/UK

CPT code(s) CCSD code(s)

Description

Costs

For treatment in Germany (DRG) please confirm Base Price (Basisfallpreis)

Estimated length of stay night(s)☐ / day(s)☐ (tick as appropriate)

Is a package price being offered? Yes☐ No☐ If Yes, please state the price offered incl. currency:

If No, please provide a breakdown of estimated costs:

Hospital charges	Doctor/anaesthetist fees	Total estimated costs incl. currency

Medical provider details

Hospital/facility name

Address (including country)

Email (mandatory)

Phone (incl. country and area codes)

Fax (mandatory) (incl. country and area codes)

	Referring doctor	Attending/admitting doctor
Name		
Email (mandatory)		
Phone (incl. country and area codes)		
Fax (mandatory) (incl. country and area codes)		

Please sign, date and authenticate with an official stamp.

I confirm that all the details given in this form are, to the best of my knowledge, true, accurate and complete.

Official stamp of medical provider

Doctor's signature _____

Date D D / M M / Y Y Y Y

Please send this fully completed **Pre-authorisation Form** at least five working days before treatment by:

Email to: **info@talent-trust.com**

If you have any queries please contact us:

Helpline : **+ 353 1 9075903**
or email: **info@talent-trust.com**

FRM-PreAuth-TT-EN-0524