Allianz Care

Treatment Guarantee Form/ pre-Authorisation to hospital

Treatment Guarantee is not required in advance of emergency treatment. However either you, your physician, one of your dependants, or a colleague must inform Bajaj Allianz General Insurance Company Ltd or Allianz Care (in case treatment is outside India) 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 person taking treatment, 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/authorisation is subject to the Standard Terms and Conditions of the insurance policy. It is also subject to our assessment of all the relevant information and documentation we need in respect of this medical condition.

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

Allianz Care 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 Treatment Guarantee/authorisation request

Name

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

Telephone COUNTRY CODE AREA CODE

Mobile telephone COUNTRY CODE AREA CODE

Email

Please send this fully completed Treatment Guarantee Form at least five working days before treatment by one of the following:

Email to: medical.services@allianzworldwidecare.com

Fax to: + 353 1 653 1780

Post to: Medical Services Department, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

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: **client.services@allianzworldwidecare.com**
For our latest list of toll-free numbers, please visit: www.allianzcare.com/toll-free-numbers

FRM-TG-AZIndia-EN-0322

Declaration by the policyholder/ patient/ representative

(a) I certify that to the best of my knowledge, this Treatment Guarantee Form does not contain any false, misleading or incomplete information nor supporting documents submitted are in anyway forged/fabricated. I understand that in the event that information regarding this Treatment Guarantee Form is found to be false, fraudulent, in whole or in part, the insurance contract will be cancelled from the date of discovery of the fraudulent event which is apart from forfeiting the premium and I may be liable to prosecution.

(b) 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 hospital/medical establishment/nursing Home to provide relevant medical information/original documents about/ relating to me, if requested by the company/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.

(c) I agree to sign on the final bill and the discharge Summary, before my discharge.

(d) Payment to hospital/medical establishment/nursing home is governed by the Standard Terms and Conditions of the Policy.

(e) In case the company is not liable to settle the hospital and treatment bill, I undertake to settle the bill as per the Standard Terms and Conditions of the Policy.

(f) All non-medical expenses and expenses not relevant to current hospitalization and treatment and the amounts over & above the limit authorized by the company not governed by the Standard Terms and Conditions of the Policy will be paid by me.

(g) I hereby declare to abide by the Standard Terms and Conditions of the Policy and if at any time the facts disclosed by me are found to be false or incorrect, and the policy becomes void ab initio and also agree to indemnify the company.

(h) I agree and understand that the company is in no way warranting the service of the hospital/medical establishment/nursing home and the company/Allianz Care is in no way guaranteeing that the services provided by the hospital/medical establishment/nursing home will be of a particular quality or standard and or deficiency of their services.

(j) I agree to indemnify the hospital/medical establishment/nursing home against all expenses incurred on my behalf, which are not reimbursed by the company.

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 applicable privacy laws in India for treatment and or claims outside India, 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 years of age must provide their own consent.

Provided however, the policyholder (upon our issuing the policy) and the patient shall be deemed to have given express consent (as required hereinabove under Indian Laws) as per privacy policy at **https://www.bajajallianz.com/about-us/privacy-policy.html** and in this regard the policyholder and the patient undertake not to dispute or raise concerns as to his/her consent. You are deemed to have given express consent to us, upon your accessing/browsing to our website, upon continued customer relations with us. You are also deemed to have given express consent to us for our sharing to our group companies, our sharing to our service providers/vendors (in India or outside India) who help BAGIC in policy/claim servicing or for other services to be availed by us our for our processing for renewal/ cross selling/upselling BAGIC products/services. I agree that my consent in this form is deemed as express consent to the company/Allianz Care for all purposes required under applicable Laws.

We care about your personal data protection

Our Data Protection Notice explains how Bajaj Allianz General Insurance Company Ltd ("Company", "We", "Us", "Our") use and or protect your privacy. This is an important notice which outlines how we our service providers will process your personal data and should be read by you before the submission of any personal data to us. To read our Privacy Policy visit: **https://www.bajajallianz.com/about-us/privacy-policy.html.**

If you have any queries about how we use your personal data, you can always contact us by e-mail at: **agichelp@bajajallianz.co.in**

2 Treatment details to be fully completed by the Medical Provider

- If additional treatment is required, the company/Allianz Care must be notified.
- Please note that all invoices/bills should be submitted within 60 days of patient discharge. However, where we have agreed special arrangements with the hospital/ medical provider /nursing home, 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 admission date D D / M M / Y Y Y Y

Planned procedure/treatment

For treatment in the USA/UK

CPT code(s) CCSD code(s)

Description

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

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

Our Hospital/medical establishment/nursing home/doctor declare, agree, and undertake as under:

(a) We have no objection to any authorized official of the company/Allianz Care verifying documents pertaining to hospitalization and treatment of the above Patient and take copy of any required document/s.

(b) All valid original documents duty countersigned by the insured/Patient will be sent to the Company/Allianz Care within 7 days of the Patient's discharge.

(c) All non-medical expenses, OR expenses not relevant to hospitalization or illness of Patient, OR expenses disallowed in the Authorization Letter of the Company, OR arising out of incorrect information in the Treatment Guarantee/pre-authorisation form will be collected from the Patient/insured.

(d) We agree that the Company/Allianz Care will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.

(e) The patient declaration has been signed by the Patient or by his representative in our presence.

(f) We agree to provide clarifications for the queries raised regarding this hospitalization/treatment of the Patient and we take the sole responsibility for any delay in offering clarifications.

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