Pre-authorization Form

Pre-authorization from Allianz Worldwide Care Services:

Please inform **Allianz Worldwide Care Services** of all planned **hospital admissions outside Egypt** by sending a completed Pre-authorization Form at least five working days prior to treatment by:

- Scan and email to: **IGOmedical@allianzworldwidecare.com** or
- Fax to: **+32 2 2106597** or
- Post to: Medical Services Department, Allianz Worldwide Care Services, Place du Samedi 1, 1000 Brussels, Belgium.

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

Our Helpline (**+32 2 2106501**) can take Pre-authorization details over the telephone **if treatment is due to take place within 72 hours**. Please have as many details as possible to hand when calling, including the contact details of your doctor.

If you have any queries please contact our Helpline on: +32 2 2106501 or email: IGOhelpline@allianzworldwidecare.com

Pre-authorization from MEDMARK:

Please inform **Medmark** at least one week in advance of all planned **hospital admissions in Egypt**.

Tel: +2 02 33039044

Fax: +2 02 33039041 (Sun to Thurs from 9:00am to 5:00pm)

Medical emergency hotline: +2 012 210 9494

Medical emergency e-mail: ops@medmark.eg

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

Section 2 must be fully completed by the doctor

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS.

Failure to complete this form fully will delay our ability to guarantee your treatment as we may have to revert to you or the medical provider for further information. The patient's policy must be in force at the time of treatment. Please be advised that guarantee of payment is subject to the terms and conditions of the insurance policy and also subject to the assessment of all relevant documentation received, or yet to be received, by Allianz Worldwide Care Services 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 (DD/MM/YY)

Contact person *please specify who should be contacted regarding the progress of this Pre-authorization request*

Name

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

Telephone (incl. country and area codes)

Mobile telephone (incl. country and network codes)

Email

Data Protection and release of medical records

In these statements, references to information include personal data and information given by you to us, whether in your application, any Claim Form or Pre-authorization Form and/or supporting documents or any information we may collect in connection with any product or service we provide. Allianz Worldwide Care Services, a member of the Allianz Group, shall be the data controller in respect of all such information.

Uses: Information you supply may be used for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention) by us. Allianz Worldwide Care Services may use third parties to process data on its behalf. Such processing, which may be undertaken outside the European Economic Area (EEA), is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Disclosure: We may share information which we hold about you and/or your claims history with our agents, members of the Allianz Group, other insurers and their agents, service providers, and with any intermediary acting on your behalf. We may also share the information with recognised, governing, and regulatory bodies (of which we are a member or by which we are governed). We may in certain circumstances use private investigators to investigate a claim you have submitted.

Sensitive data: We need to collect sensitive data relating to you (such as medical and health details) in order to assess the terms of insurance we issue/arrange or to administer claims which arise.

Retention: We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than is necessary and we will hold it only for the purposes for which it was obtained.

Consent: By providing us with your information and by signing this Pre-authorization Form, you consent to all of your information being used, processed, disclosed and retained as set out above.

Representation: By your signature you warrant and represent to us that you have authority to act on behalf of your dependants in respect of all personal information you provide to us, you have the authority of your dependants to disclose this personal information for the uses listed above and you are consenting to the processing, disclosure, use and retention of your dependants information on their behalf. In these statements, all references to "you" or "your" shall be deemed to include both you and your dependants.

Access: Under the Data Protection Acts 1988 and 2003, you have the right to request and receive a copy of your personal data held by us. Should you wish to exercise this right, you should send the request in writing and address it to the Data Protection Officer, Allianz Worldwide Care Services, Place du Samedi 1, 1000 Brussels, or by email to: IGOhelpline@allianzworldwidecare.com. A fee of €6.35 is chargeable under the terms of the Data Protection Acts and cheques should be made payable to Allianz Worldwide Care Services.

Call recording: Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

I hereby authorise my medical practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Allianz Worldwide Care Services or their appointed representatives.

If a minor was treated, a parent or guardian should sign this section.

Patient's signature

Date (DD/MM/YY)

Allianz Worldwide Care Services

2 TREATMENT DETAILS *to be fully completed by the Medical Provider*

- If additional treatment is required, Allianz Worldwide Care Services must be notified.
- If invoices are received more than 60 days after patient discharge, acceptance of liability for those expenses remains at the discretion of Allianz Worldwide Care Services. Please note that where local regulatory rules or special agreed arrangements with Allianz Worldwide Care Services differ, such rules and arrangements will apply.

Condition

Description of the condition, signs and symptoms

Underlying cause (if known)

Date this condition was first diagnosed (DD/MM/YY): Date of first attendance for this condition (DD/MM/YY):

On what date would the first onset of symptoms have been apparent to the patient (DD/MM/YY)?

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 (DD/MM/YY): Expected or actual date of delivery (DD/MM/YY):

Is birth of a single baby expected? Yes ☐ No ☐ If **No**, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes ☐ No ☐

Delivery method

Treatment

Planned procedure/treatment

Planned admission date (DD/MM/YY):

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 Physician/anaesthetist fees

Room: Private (mandatory) Semi-private (mandatory)

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 physician

Name

Email (mandatory)

Telephone (incl. country and area codes)

Fax (mandatory, incl. country and area codes)

Attending/admitting physician

Name

Email (mandatory)

Telephone (incl. country and area codes)

Fax (mandatory, incl. country and area codes)

Please sign 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.

Doctor's signature

Date (DD/MM/YY)

Official stamp of medical provider

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