Allianz AYUDHYA

Claim form for medical treatment reimbursements

Please complete clearly in BLOCK CAPITALS.

One form must be completed for each patient, for each medical condition treated.

Sections A to D and section F have to be completed by the patient, or the main member on behalf of the patient if the patient is a dependant under the age of 20. Section E has to be completed by the patient's medical practitioner, specialist or therapist, unless the claim is for a repeat prescription for medication to treat a chronic medical condition and we have previously approved and paid claims for the same medication to treat the same chronic medical condition.

Further information about how to complete this form can be found in the Claims procedures.

Failure to complete all sections of this form may result in delays.

Section A: Patient details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ Male ☐ Female
Member number:	Plan number:

Correspondence address:

Town:	Postcode:	Country:

Email:

Daytime phone: | Evening phone:

Section B: Main member details (if different from section A)

Family name (surname):	First name(s):
Member number:	Plan number:

Section C: Claim details

Detail the symptoms/medical condition that the patient received treatment for:

Is this claim for a wellness checkup? ☐ Yes ☐ No If 'Yes', section E does not need to be completed.

If this claim is not for a wellness checkup, is it:
a new claim? ☐ Yes ☐ No If 'No', provide the previous claim number:
a claim for a repeat prescription? ☐ Yes ☐ No If 'Yes', section E does not need to be completed.

Is this a claim for hospital cash benefit? ☐ Yes ☐ No

If 'Yes', send us the original admission and discharge form from the hospital where the treatment was provided. Section E must also be completed by the medical practitioner or specialist.

If 'No', provide the breakdown of the receipts being submitted with this claim:

Date of treatment (dd/mm/yyyy)	Receipt date (dd/mm/yyyy)	Receipt reference	Amount (including currency)

Use a separate sheet if you need more space.

Does the patient have another insurance plan or policy that covers medical costs? ☐ Yes ☐ No

If 'Yes', provide the other insurer's details including the name of the insurer, the insurer's address and the patient's plan or policy number with that insurer:

Section C: Claim details (continued)

Is the claim as a result of an accident?	☐ Yes ☐ No
If 'Yes', provide the circumstances of the accident including how it happened, the location, the time and the date, using a separate sheet if you need more space:	
If the patient has suffered an injury as the result of an accident, are they claiming from a third party?	☐ Yes ☐ No
If 'Yes', provide the other insurer's details including the name and the plan number below:	

Section D: Data Protection and Declaration – the Declaration must be signed by the patient or the main member if the patient is a dependant under the age of 20

Data Protection Notice

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with relevant legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

Your information may also be used for the detection and prevention of fraud and for audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to Law enforcement and other legal agencies, governmental or judicial bodies, or to regulators.

Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.
If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

We will communicate directly with you about your claim if you are aged 20 or over, or with the main member if you are under 20 unless we are advised otherwise. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information, or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below.

I would like information about this claim to be provided to:

Name:	**Relationship:**

Declaration

I declare that all the details given on this Claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I may be committing a criminal offence and that this may invalidate the plan. I authorise any medical practitioner, specialist, therapist or other relevant establishment who has attended me/the patient in the past, or is attending me/the patient at present, to give any details that may be asked for by the insurer or its duly appointed administrators or authorised agents.

I confirm that I give explicit consent (on behalf of myself and any family members specified in this form) for the insurer or its duly appointed administrators or authorised agents to process our personal information with respect to our membership and I confirm that I have brought this Data Protection Notice to the attention of these family members.

I authorise and request any hospital, specialist, physician or other health provider to furnish the insurer or its duly appointed administrators or authorised agents with such information as they may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of the consideration of this claim.

Patient's/main member's signature:	**Date (dd/mm/yyyy):**

Section E: Medical – must be completed by the medical practitioner/specialist/therapist

1. Contact and registration details

Name of medical practitioner/specialist/therapist: Qualifications:

Phone: Fax:

Email:

Date the patient first registered with you/the clinic/the hospital (dd/mm/yyyy)

2. Symptoms

a) Provide full details of the symptoms presented:

b) Has the patient suffered from the same or similar symptoms before? ☐ Yes ☐ No
If 'Yes', are the symptoms related to a previously diagnosed medical condition? ☐ Yes ☐ No
If 'Yes', specify the medical condition:

c) On what date did the patient first notice these symptoms (dd/mm/yyyy)?

d) On what date did the patient first present these symptoms to you (dd/mm/yyyy)?

3. Diagnosis

Diagnosis of medical condition, if known: ICD10 code:

Is there any underlying cause? ☐ Yes ☐ No
If 'Yes', provide details:

Is the medical condition as a result of an accident? ☐ Yes ☐ No
If 'Yes', was the patient under the influence of alcohol or any other intoxicating substance at the time of the accident? ☐ Yes ☐ No

Treatment proposed:

Investigations requested, if any:

In your opinion, is this condition: ☐ Acute ☐ Chronic ☐ Acute episode of a chronic condition

4. Type of complementary treatment recommended, if relevant:

☐ Physiotherapy ☐ Osteopathic ☐ Chiropractic ☐ Homeopathic ☐ Acupuncture ☐ Traditional Chinese medicine ☐ Podiatry

Number of sessions needed:

5. Referrals

a) Was the patient referred to you? ☐ Yes ☐ No
If 'Yes', please complete 'Section E: Medical (continued)' on the back page.

6. Hospital admission

Has the patient been admitted to hospital for this condition? ☐ Yes ☐ No
If 'Yes', provide the following details:

Admission date (dd/mm/yyyy): Discharge date (dd/mm/yyyy):

7. Declaration

I declare that to the best of my knowledge and belief the information I have given in the Medical section of this Claim form is full, true and complete.

Medical practitioner's/specialist's/therapist's signature:

Date (dd/mm/yyyy)

Practice stamp:

Section E: Medical (continued)

5. Referrals (continued)

Name of referring practitioner:	Date of referral (dd/mm/yyyy):
Qualifications:	Phone:

b) Have you referred the patient? ☐ Yes ☐ No

If 'Yes', provide the following details:

Name of specialist you referred the patient to:	
Date of referral (dd/mm/yyyy):	Phone:

If available, please provide a copy of the referral letters.

Section F: Payment details

Have you personally had to pay costs for the treatment that you are claiming for? ☐ Yes ☐ No

If 'Yes', and you are personally seeking reimbursement, please fill in the details below.

We will only issue payment to:

- the patient if they are 20 or over;
- the planholder if the patient is under 20 and is a dependant under the plan; or
- the parent or legal guardian named as the planholder if the patient is the main member and is under 20.

If another person or entity has paid on your behalf please give their name:

Failure to complete all information may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement; and
- incurring additional bank charges.

Name of account holder:

If the patient's name (as given in section A) is different to the account holder name, please provide the following details:

Address of account holder:

Email address of account holder:

Telephone number of account holder:

Bank account details:

Bank name:

Bank address (including town and city):

BIC/SWIFT code:

Currency of bank account:

Account number:

To help us direct your payments efficiently, supply the following as relevant:

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks):

Routing Code/Branch Code (as available):

ABA number (mandatory for transfers to US located banks):

Important information

Please remember these important points when completing your Claim form:

- Assessment of your claim may be delayed if you and your medical practitioner do not complete all the necessary sections of this form.
- Send your claim to us as soon as possible. We recommend that you do so within a maximum period of six (6) months of the first treatment date.
- Always send us the original receipts with this form. Photocopies and credit card statements will not be accepted.

Section A – Patient details

- If the patient is a dependant under the age of 20, the main member must complete the form and sign the declaration for them. If the patient is a member under the age of 20, the parent or legal guardian named as the planholder must complete the form and sign the declaration for them.

Section C – Claim details

- I f you have another insurance plan or policy that covers you for medical costs, we will need to know the details as it may affect the amount we pay in respect of your claim.

Sections D and E

If the declarations have not been read and signed, we will not be able to process your claim.

Section F – Payment details

If you are not personally seeking reimbursement we will pay the treatment provider directly, as long as the payment instructions are shown clearly on the invoice.

i. Ensure that you are able to receive payment in the currency you have requested.

ii. We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.

iii. We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details .

iv. If you do not give us the sort code/routing code, BIC/SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.

v. We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the currency of your plan. For the current list of applicable currencies and countries please refer to our website.

vi. Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.

No-claims discount

The no-claims discount applies to individual and family plans only. Claims made under the dental benefit will affect your no-claims discount.

The no-claims discount does not apply to groups.

Deductibles

Any applicable excesses and co-insurances will be deducted from any reimbursement.

Checklist

Please send your claim to us by post. Please check you have included:

- a fully completed Claim form with signed and dated declarations ☐
- original receipts ☐
- original itemised invoices ☐
- other relevant documentation ☐

Photocopies, receipts and credit card statements are not acceptable.
We are unable to return original documents, but are happy to provide certified copies on request.

- an original hospital admission and discharge form if claiming hospital cash benefit ☐

Please call us on +66 (2) 662 8280 press 4 or email th-claims@aetna.co.th if you require any further assistance.

Send your claim to: IPMI Claims Team, Allianz Ayudhya General Insurance Public Company Limited.

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T +66 (2) 662 8280 press 4 Office hours: 08.30-17.30