Allianz AYUDHYA

Claim form for maternity treatment reimbursements

Please complete clearly in BLOCK CAPITALS.

Sections A, B, C, D and 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 medical practitioner, specialist or therapist.

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: ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Plan number:
Member number:	Daytime phone:
Evening phone:	
Correspondence address:	
Town:	Postcode: Country:
Email:	

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

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

Section C: Claim details

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)

Does the patient have another insurance plan or policy that covers medical maternity 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 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: Maternity treatment – must be completed by the medical practitioner/specialist/therapist

Name of medical practitioner/specialist/therapist: Qualifications:

Phone: Fax:

Email:

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

Date of the patient's LMP (dd/mm/yyyy):

How many weeks pregnant is the patient?

Is the pregnancy a result of any infertility treatment including infertility medication or conception by artificial means? ☐ Yes ☐ No

Expected type of delivery: ☐ Normal Vaginal Delivery ☐ C-Section

If 'C-Section', advise the reason:

Provide relevant details of any previous complicated pregnancies or complicated childbirth:

Does the patient suffer from any medical conditions that might put the current pregnancy at risk: ☐ Yes ☐ No

If 'Yes', provide details:

Is the reason for this visit: ☐ Routine antenatal checkup? ☐ Antenatal complications?

If this visit is for 'Antenatal complications' provide details:

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

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

Date (dd/mm/yyyy):

Practice stamp:

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):

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.
898 Ploenchit Tower, Ploenchit Road, Khwang Lumpini, Khet Pathumwan, Bangkok 10330
T +66 (2) 662 8280 press 4 Office hours: 08.30-17.30