Allianz

International Healthcare Plans for Mexico

Pre-authorization Form

For your convenience, this form is also available on our website:
https://www.allianzcare.com/treatment-guarantee-form-international-healthcare-plans
Please complete this form in **BLOCK CAPITALS**.

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

Our Helpline (**+ 353 1 630 1301**) can take pre-authorization 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 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 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 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-authorization request

Name

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

Telephone COUNTRY CODE AREA CODE

Mobile telephone COUNTRY CODE AREA CODE

Email

Privacy Notice

Allianz México, S.A. Insurance Company (hereinafter, "Allianz") with address located at Boulevard Manuel Ávila Camacho No. 164, Colonia Lomas de Barrilaco, Mayor's Office Miguel Hidalgo, C.P. 11010, in Mexico City, Mexico, will use your personal data collected here to: A) verify, confirm and validate your identity; B) evaluate your insurance application and risk selection or the circumstances to, where appropriate, enter into contracts with Allianz; C) comply with the obligations derived from the insurance contract that, where appropriate, is entered into; D) deliver all the documentation that is derived from the insurance contract that, where appropriate, is entered into; E) operate and monitor the insurance product requested or contracted with Allianz; and F) prevent and detect fraud and / or illegal operations.

For more information about the treatment and the rights that you can assert, you can access the comprehensive privacy notice through our website: https://www.allianz.com.mx/aviso-de-privacidad (only available in Spanish).

We need your consent

We need 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 Online Services and tick the required fields. A paper copy is available on request. Please note that every member on the policy over 18 needs to provide their own consent.

I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorize my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information relating to me, if requested by Allianz, its medical advisers, 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

2 Treatment details to be fully completed by the Medical Provider

- If additional treatment is required, Allianz must be notified.
- Please note that all invoices should 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/anesthetist 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)		

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-authorization Form at least five working days before treatment by one of the following:

Email to: medical.services@allianzworldwidecare.com or

Fax to: + 353 1 653 1780 or

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/en/pages/toll-free-numbers.html