International Healthcare Plans for Qatar

Claim Form

Please complete this form in BLOGK CAPITALS. For your convenience, this form (in PDF format) is available on our website; www.alliauzworldwidecare.com/cfq.



Quick and easy claims submission

- 1. Provide a few key details
- Take a photo of your receipt(s)

And you're done

www.allianzworldviidecare.com/myhealth

Policy Number					
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Date of birth (00/MM/YY)	Landon Alexandra &				
Latest correspondence address					
Telephane number (inc.) country code and	pred code)	entre (A. 1810) in the exist event (—e ex-	, sprovenpagonio della della	/	emerkii makanen belever
Email					
Patient's details (if diffe	rent from policyholder)				
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Claim details

Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount charged. If your invoice/receipt does not include the diagnosis/medical condition, please ensure that you provide us with this information below. If there is not sufficient space in the table below, please provide details on a separate page.

Description of expense/treatment	Diagnosis/medical condition	Provider's name	Amount charged/ currency	Has this b	oill been / you?
Male III compaire Gilly	K02.62	Cuni	Ach 200	Yes	No 🗆
Class III composit filling Class III composite Cilly Mophylapis			AT 200	Yes 🗆	No □
1 1100/201				Yes □	No □
				Yes 🗆	No 🗆
				Yes □	No 🗆
				Yes 🗆	No 🗆
				Yes 🗆	No □
		7.50		Yes □	No 🗆
,		1/37 (13	Yes 🗆	No 🗆
		* DENTÍS	1 1 1	Yes □	No □
		Medical Medica		Yes 🗆	No 🗆
		TREE D	NATION.	Yes □	No □
				Yes □	No □
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				Yes 🗆	No □
Water and the second se				Yes □	No □
				Yes □	No □
				Yes 🗆	No 🗆

In what country did the treatment take place?

WAT

Has pre-authorization been obtained?

Yes □ No □

If this claim is resulting from an accident or work-related illness/injury and you hold any other insurance policy (e.g. car insurance), or if you are filing a claim or lawsuit against a third party to recover the costs incurred as a result of this accident/injury, please provide details in a separate document.

 $Sections\,5\,and\,6\,are\,to\,be\,completed\,by\,the\,treating\,doctor\,unless\,detailed\,in\,the\,supporting\,documentation\,(e.g.\,receipts\,or\,invoices).$

	5	Medical provider's details					
		Name of doctor/specialist No Months 154 m.d.					
		Qualifications/credentials Guren Juntst					
		Name of hospital/clinic Nambular Rental Clinic					
		Address In wal Part Vyrs Man Ha		WI Mercah I			
		medi nat					
		Telephone number (incl. country code and area code)	-2529935				
		Fax number (incl. country code and area code)					
		Email dentitedantel clinic 1@ gmail-con					
		Applicable to physiotherapy/psychotherapy claims only. Please provide full r	referral details:				
		Name of referring physician					
		Telephone number (incl. country code and area code)					
		Date of referral (DD/MM/YY)					
/	6	Medical details					
		Indicate type of treatment received Elective	Emergency				
		Indicate type of condition Acute □	Chronic 🖃	Acute episode of chronic □			
		Please provide full details of the symptoms/medical condition requiring treatmen	nt, including ICD9/10 code/DSM-IV	T 10 10 10 10 10 10 10 10 10 10 10 10 10			
		Dental covins on Smooth conface 1	Constration into destin	KO2-62 Footh HILL			
		Dental cories on smooth surface of Dental caries on smooth surface pan	etrating into denting	(02,62 took # 22			
		Deposits [Accordions] on text.	1563-6				
		topo 15 Charles and an inches					
		On what date did the patient first present these symptoms to you? (DD/MM/YY)					
		On what date would the first onset of symptoms have been apparent to the pati	ient? (DD/MM/YY)	1. 1. 1			
		Has the patient suffered from this condition previously? Yes □ No □	/				
		Are you aware of any treatment given for this or any related illness in the past?	Yes 🗆 No 🖾				
		If Yes, please provide details					
		Is it likely to re-occur? Yes ☑ No □					
		Does it need rehabilitation? Yes □ No 🗹					
		Is it permanent? Yes \(\sigma \) No \(\sigma' \)					
		Does it need long term monitoring, consultations, check ups, examinations or te	ests? Yes 🗆 No 🗗				
		Applicable to cases of pregnancy only:					
		Estimated date of delivery (DD/MM/YY) Is birth of a single baby expected? Yes No					
		If you answered No to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination?					
		A CARLO CONTRACTOR OF THE CONT	the pregnancy a result of medically assisted repre	dictorrower distribution in serving con-			
		Yes No					
		If Yes, please provide further details					
	Applicable to dental treatment claims only:						
	Was the patient suffering from dental pain at the time he/she visited you for treatment? Yes No No						
		The Additional Control of the Contro					
		Please sign and auther ticate with an official stam Mostafa Abdall	a	Official stamp of medical provider			
		General Dentist		Parities preside naviscotores baseages			
		DENTÍSTREE DHA-00222048-001		1/3/ 1/10 = 10			
		DENTISTBEE DENTAL CLINIC	C	O STREET			
		Doctor's signature		DEN MARION			
		Date (DD/MM/YY) 21 0 2 2024	Associations (12/1			
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Data Protection and release of medical records



References to information includes personal information given by you to us, in your Application, Claim or Pre-authorization form and/or supporting documents/information we collect in connection with products or services we provide. Allianz Worldwide Care, part of the Allianz Group, is the data controller for this information.

Uses: Personal information may be used for insurance administration (e.g., underwriting, claims handling, fraud prevention). We may use third parties to process data on our behalf. Such processing is subject to contractual restrictions regarding confidentiality and security in line with Data Protection obligations:

Sensitive data: We need to collect sensitive data relating to you (e.g. health details), to assess insurance terms and/or administer claims.

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

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 necessary and will hold it only for the purposes for which it was obtained.

Representation and Consent: By signing this form you confirm that you have the authority to act on behalf of your dependants in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependants.

Access: You have the right to request and receive a copy of your personal data held by us. If you wish to do this, please write to the Data Protection Officer at the address provided on this form or via client services@allianzworldwidecare.com.

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

Direct marketing: Personal data collected by us will not be used to contact you for direct marketing purposes, unless you have consented to this.

Legify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent, in whole or in part, the contract will be concelled from the date of discovery of the fraudulent event and I may be liable to prosecution.

Lagree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and Lagrhorise my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information relating to me, if requested by Allianz Worldwide Care, 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 this section.

Patiént's signature	Date (DD/MM/YY) i
Third party authorisation	
As the claimant, I hereby authorise to act for and on my behalf in relation to the admin	NASERT NAME OF THIRD PÁRSY ration of this claim, which may include the disclosure of sensitive medical information.
Claimant's signature	Date (DD/MM/xx)

Please send your fully completed Claim Form(s) with invoices/receipts as follows:

Scan and email to:

claims@allianzworldwidecare.com

Fax to:

+353 1 645 4033

Post to:

Claims Department, Allianz Worldwide Care, 15 Joyce Way, Park West Business Campus, Nangor Road,

Dublin 12, Ireland.

It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claims settlement for fraud detection purposes. In addition, 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.

Please contact our Helpline if you have any queries: +353 1 517 6988 or email: client.services@allianzworldwidecare.com.

For our latest list of toll-free numbers, please visit: www.allianzworldwidecare.com/toll-free-numbers

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Important - please check the follow	ine:			
		The disposition is	een confirmed and is either stated	on the Claim Form action the
 Alfizeceipts, invoices and prescri 		The diagnosis inst	regritorini regalio is citret socci	iditue danitum o orde
□ The Claim Form is completed in	full,	unvoice(s).		
☐ The declarations are signed and	dated	☐ If you have change	d your contact details, please let us	know on the Claim Form.
_ nacceptations are significant	rw-u			