Allianz AYUDHYA

Pre-arrangement Form

Customer service Tel.02-232-8666 Fax.02-230-6556 / Pre-authorization Tel.02-677-0553 Fax.02-230-6553

Date ..... Pre - arrangement No. .....

Part 1 For Customer

Patient Name .....DOB.....Age..... Yrs. Sex .....

Current Address .....Telephone Number .....ID Card No/ Passport No.....

Policy Number..... Effective date .....Expired date.....

Other Co-Insurance(If any) ..... Policy Number .....

Date of treatment ..... Hospital Name.....

Purpose to visit .....

1. I authorize the physician/health care provider or any individual giving me medical treatment to provide a photocopy of my health record or related document health including the treatment of nervous and mental disorders, treatment of HIV and AIDS to Allianz Ayudhya General Insurance PCL or its representative. Photocopy of this statement shall be as effective and valid as the original.
2. I agree that all my eligible medical expenses will be settled in accordance with my policy terms and conditions, by Allianz Ayudhya General Insurance PCL or its representative directly to the hospital.
3. If, for any reason, it should be found after treatment that my expenses are not eligible for benefit, I agree to reimburse the hospital directly.
4. In the event that I do not pay the hospital directly and it is subsequently found after treatment that my expenses are not eligible for benefits, I agree to reimburse Allianz Ayudhya General Insurance PCL within 7 days if notification.
5. I agree that if I am able to claim part of the eligible expenses from another third party, Allianz Ayudhya General Insurance PCL has the right to deduct this amount from my claim.

Signature ..... Date.....

(.....)

Part 2 For Attending Physician

Physician's Name .....

Medical Specialty.....Medical License No. .....

Vital Signs T.....PR.....RR.....BP.....

Chief complaint duration .....

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Underlying condition .....

Present Illness or cause of injury .....

Diagnosis .....

Plan of Treatment .....

Procedure ..... ICD9-CM .....

Anesthesia type ( ) GA ( ) SB ( ) LA ( ) Others

Pathological test .....

Surgery type: ☐ Day case

☐ IPD case

if yes please provide **indication for admission**.....

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Expected LOS ..... Days Expected cost.....THB

Signature..... Date.....

Part 3 For Allianz Ayudhya

Based on claim documents received , we would consider as follows.

( ) We confirm to use credit SURGERY _____ %

( ) We regret that we are unable to provide an authorized the use direct billing to us.....

Please submit attending physician summary to us on discharge. This direct credit is only for the procedure/ or treatment state on this form.

Signature _____Assessor Date_____