Allianz

ZAD Allianz Bulgaria

REQUEST FOR INPATIENT MEDICAL CARE

under "ALLIANZ HEALTH" group medical insurance

INFORMATION ABOUT THE INSURED PERSON:

Name as per identification document: .....

Personal №/Foreigner's №: ☐☐☐☐☐☐☐☐☐☐ INN: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(Individual notice number)

Address: .....

Cell phone: +359 ..... Email: .....

Legal representative/proxy: .....
(name as per identification document)

Personal № /Foreigner's №: ☐☐☐☐☐☐☐☐☐☐

INFORMATION ABOUT THE HOSPITAL PERSON:

Diagnosis: ..... Medical Classifier of Diseases Code: ☐☐☐.☐☐

Clinical pathway / Ambulatory procedure № .....

Hospital establishment: ..... Date of admission: .....
(name)

Dear ladies / gentlemen,

Please confirm a coverage for use of the following services under INPATIENT MEDICAL CARE Health Module, besides funding by the National Health Insurance Fund for the following Clinical pathways / Ambulatory procedures:

Type of service	Single cost	Pcs.	Total cost for the service
1.			
2.			
3.			
4.			
5.			

PLEASE FIND ENCLOSED THE FOLLOWING DOCUMENTS

1. .....
2. .....
3. .....
4. .....

By signing this request, I hereby declare that:

- the information I have provided is true and accurate;
- I am acquainted with the insurer's *Data Protection Communication*;
- the healthcare commodities and services, included in the request, have not been claimed, refunded and/or paid by third parties, including the insurer or other insurers and National Health Insurance Fund.

Applicant: ……..…….. Date: ….……..……

(Full name and signature) Place.: ……..……....

Note: Only people above 14 years of age who carry out legal actions alone with the consent of their parents or guardians sign the request. Children under 14 years of age are represented by their legal representatives – parents or guardians.

TO BE COMPLETED BY THE TREATING PHYSICIAN / HOSPITAL REPRESENTATIVE

Hospital establishment:

……

Treating physician: ……

Planned admission date: ……...

Medical information: ……...

……

……

……

On behalf of the hospital establishment: ……..

(Full name and signature)

Date: ….……..……....

Position: ……..…… Place.: ……..……..

TO BE COMPLETED BY THE INSURER:

Statement:

……..…

……..…

……..…

……..…

On behalf of the insurer: …… Date: ...……..……..

(Full name and signature)

Place: ...……..……..