Allianz medical insurance form

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Thomasville-Archdale/Trinity Pediatrics

Consent for Ear Piercing

Patient Name _____ **Date of Birth** _____

PLEASE INITIAL FOR CONSENT:

____ I understand that fees for ear piercing will not be filed against any insurance. All payments for this service are due at the time of the visit.

____ I understand that my child's ears will be pierced with pre-sterilized, single use, medical grade plastic or titanium earrings.

____ I acknowledge that if my child has a bleeding disorder, diabetes, high blood pressure, immune disorder, heart condition, allergies or a skin disorder, then ear piercing may carry a greater risk for my child. My child's pediatrician and I have discussed the risks and benefits of ear piercing with these medical conditions, prior to the procedure.

____ I understand that ear piercing is a minor surgical procedure with similar risks to stitches or abscess drainage. Despite all precautions that are taken by Thomasville-Archdale/Trinity Pediatrics and my proper aftercare treatment, the potential for infection still exists. There is also the potential that one of the following complications may occur as a result of ear piercing:

Persistent redness	Bacterial infection of the blood (septicemia)
Swelling	Abnormal healing of the ear such as keloid scarring or cauliflower ear
Drainage from piercing	
Bleeding from piercing	Pressure sore
Embedded clasp	Traumatic injury
Local wound infection/cellulitis	

**Please contact Thomasville-Archdale/Trinity Pediatrics if you experience any of these symptoms.

____ I have read and understand the AFTER CARE INSTRUCTIONS and have received a copy for my reference. Aftercare of piercing is the responsibility of the parent or patient, once they leave the office.

____ I agree that if at any time, it is deemed unsafe for my child or the medical staff to continue with the procedure, then the procedure will be stopped and potentially rescheduled for another time.

____ I have agreed to this ear piercing procedure and I am fully aware of the potential risks and complications of the procedure.

I have read and understand all of the items listed above and I agree to their terms. By signing this document, I certify to Thomasville-Archdale/Trinity Pediatrics that I am the parent or legal guardian of the minor patient named above or I am eighteen years or older and able to consent for my own procedures.

Signature: _____ **Date** _____

Print Name: _____

Relationship to Patient: _____ **Self** ☐

Witness Signature: _____ **Date**: _____

BlueCard Worldwide®
International Claim Form

BlueCross BlueShield

Blue Cross and Blue Shield Plans are independent licensees of the Blue Cross and Blue Shield Association.

Please see the instructions on the reverse side of this form before completing. Please type or print.
Send completed form to: BlueCard Worldwide Service Center or claims@bluecardworldwide.com
P.O. Box 261630
Miami, FL 33126 USA

1. Patient Information — 1A. Alpha prefix Identification number *Copy this from your Blue Cross Blue Shield identification card.*

1B. Patient's name (First, middle initial, last)	1C. Patient's date of birth MM/DD/YYYY / /	1D. Patient's sex ☐ Male ☐ Female
1E. Name of subscriber (First, middle initial, last)	1F. Subscriber's date of birth MM/DD/YYYY / /	1G. Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child
1H. Subscriber's current mailing address (Street, city, state, and country or ZIP code)		1I. Patient's e-mail address

2. Other Health Insurance — Is the patient covered under other health insurance, including Medicare A or B? ☐ Yes ☐ No
If yes, complete 2A through 2K below.

2A. Name and address of other insuring company

2B. Type of policy ☐ Family ☐ Individual	2C. Effective date MM/DD/YYYY / /	2D. Termination date MM/DD/YYYY / /	2E. Policy or identification number of other coverage
2F. Type of coverage Medical: ☐ Yes ☐ No Hospital: ☐ Yes ☐ No Mental illness: ☐ Yes ☐ No		2G. Name of subscriber	2H. Date of birth MM/DD/YYYY / /
2I. Employer of subscriber		2J. Employment status ☐ Active employee ☐ Retired employee	

2K. If patient is covered under Medicare, complete the following: Medicare Part A: ☐ Yes ☐ No Effective date _____ Medicare Part B: ☐ Yes ☐ No Effective date _____

3. Diagnosis — 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury.

3B. Was patient's treatment due to a work-related accident or condition? ☐ Yes ☐ No

3C. Complete for care related to accidental injuries

Date of accident _____ Location: ☐ At home ☐ Auto ☐ Other _____

Time of accident _____ *If the accident was caused by someone else, attach a statement describing the accident.*

4. Charges — Use a separate line to list each type of service or provider and attach itemized bills for all services.

4A. Name and address of provider making charge	4B. Type of provider	4C. Description of service	4D. Dates of service or purchase	4E. Charges

5. Payee — Select one of the following payment options:

5A. ☐ Make payment to subscriber; provider has been paid.

1. Currency – Please check your preference for payment: ☐ **Currency on itemized bill(s)** ☐ **U.S. dollars**

2. Payment Method – Please select your preference for how to receive your payment: ☐ **Check** (Provide current telephone number) _____

☐ **Bank Wire.** If you want to receive a bank wire provide the following:

Subscriber name as it appears on bank account: _____ Bank name: _____

Bank's Physical Address: _____

Account # /IBAN: _____ Routing # / ABA / BIC / SWIFT: _____

5B. ☐ Make payment to provider (hospital, doctor), if appropriate. Please complete and sign to authorize direct payment to provider.

I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by Blue Cross and Blue Shield:

Name of provider _____ Signature of subscriber or spouse _____ Date _____

6. Signature — I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to the subscriber's Blue Cross and Blue Shield Plan and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. Authorization is also given to the subscriber's Blue Cross and Blue Shield Plan and its business associates in any country to collect, use or release any medical or other personal information that they deem necessary to provide service, adjudicate a claim or as otherwise described in such Blue Cross and Blue Shield Plan's Notice of Privacy Practices.

Signature of subscriber or patient _____ Date _____

PROVIDER REFERRAL REQUEST FORM

Referring To	Specialty:	Phone:	Fax:
	Practice Name & Address:		
	Please Schedule (select all that apply): ☐ Urgent - Referring physician called _____ ☐ Routine Appointment with Specific Physician Noted _____ ☐ First Available with any Physician		
	Referring Provider's Name:	Phone:	Fax:
Type of Visit	☐ Evaluation consultation with treatment recommendations that primary care physician will continue to follow ☐ Evaluation consultation with assumed care for this condition ☐ Evaluation consultation with treatment recommendations and shared care	☐ Specialist to Specialist* Secondary Referral *Send copy of this referral to patient's primary care physician. ☐ Other (designate) _____	
Patient Information	Patient Full Legal Name:		DOB:
	If patient is under 18 years old – Parent Contact Name:		
	Preferred Phone:	Best time to call:	
	Special Patient Considerations:		
	Patient Insurance Information:		
	Patient's Primary Care Provider:	Phone:	Fax:
Clinical Information	Reason for Referral (Clinical Question):		
	Comments/Considerations Related to Clinical Question: **Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes.**		
	Patient aware of reason for referral? ☐ Yes ☐ No, Explain:		

PROVIDER REFERRAL CONFIRMATION

Referral Accepted? ☐ Yes ☐ No: Explain:	
Appointment Scheduled with:	Date & Time of Visit:
Request for additional supporting clinical information (please detail):	
☐ Patient prefers to contact specialist to schedule at a later date	
☐ Patient declined appointment: Date: _____ Reason: _____	
☐ Patient cancelled appointment on _____ and rescheduled for _____	
☐ Patient cancelled appointment on _____ and did not wish to reschedule.	
☐ Patient was NO SHOW for appointment on _____	
Person completing confirmation:	Date of Confirmation:

Nutritional Supplement Schedule

Instructions

☐ Take supplements 30 minutes before meals.
☐ Take supplements with meals.
☐ Take supplements immediately after meals.
☐ Take supplements until completion of the prescribed quantity.
☐ Continue supplements until further instructions.
☐ Continue supplements until:
☐ Other instructions:

Supplement Breakfast		Lunch	Dinner	Bedtime	Total	

Allianz travel insurance medical claim form. Is allianz health insurance good. How do i claim my allianz health insurance. Allianz travel insurance medical report form. How much allianz health insurance cost. Types of insurance allianz. Allianz insurance medical claim form.

If you are covered by one of the International Healthcare Plans for Singapore, choose the relevant form below to claim back eligible medical expenses. (typically, consisting of 3 to 9 members) (typically, consisting of 10+ members) Home > Navigating Cancer Care > Managing Your Care > Medical Forms ASCO developed two types of forms to help people diagnosed with cancer keep track of the treatment they received and medical care they may need in the future: a Cancer Treatment Plan and a Survivorship Care Plan. A Cancer Treatment Plan is a form that provides a convenient way to store information about your cancer, cancer treatment, and follow-up care. It is meant to give basic information about your medical history to any doctors who will care for you during your lifetime. A Survivorship Care Plan is a form that contains important information about the given treatment, the need for future check-ups and cancer tests, the potential long-term late effects of the treatment you received, and ideas for improving your health. Learn more about ASCO Treatment Plans and Summaries. Writing down information during visits with your doctor can help you manage what can seem like an overwhelming amount of information. These forms include an extensive medical history form, a form for contact information and insurance information, a form to log test results and appointment notes, and a form to list members of your health-care team. Cancer.Net's medical forms are available in both PDF and Word document forms. To download a form to your computer, right-click on the link and select "Save As." PDF You will need Adobe Acrobat Reader to view the forms. If you do not have it installed already, you can download this program: My History My Health-care Team My Test Results My Appointment Notes Word Document My History My Health-care Team My Test Results My Appointment Notes Additional Resource Managing Your Care In order to provide you with the best personalised and instant service, this website uses cookies to record and access your browsing information. When you continue to browse (use) this website, you agree to the technical support of Cookies. For more information, please refer to the privacy protection statement. THE PRIVACY PROTECTION STATEMENT If you wish to withdraw from the Insurance contract and you inform us in writing within 30 days, or if you are an entrepreneur within 7 days from conclusion of the insurance agreement, we will refund the premium paid minus only the cost of coverage for the period in which we provided it. If you wish to terminate the insurance agreement, your withdrawal will be treated as binding on the last day of the month after the expiry of the one-month notice period, calculated from the last day of the month in which you informed us of your decision. Remember that you are required to pay the premium during the notice period. However, we will reimburse you for the unused period of cover, e.g. if you have paid the premium in advance for the whole year of the insurance contract. Your insurance contract will also be terminated if you have not paid the premium within the required period or if a declaration of not wishing to extend the insurance contract for subsequent annual insurance periods is made before the anniversary of the policy. Send us: a written statement of your withdrawal/contract termination. Major medical insurance provides minimum essential coverage for illness, hospitalization and preventive health care. Individuals and families who do not have access to employer coverage can obtain qualified major medical plans via the Health Insurance Marketplace or through an insurance company or broker. Plan availability can vary based on where you live, and how you purchase your insurance may impact your premium costs. What is major medical insurance? The focus of major medical insurance is providing coverage for illness, hospitalization and preventive health care. Individual major medical health insurance plans comply with Affordable Care Act (ACA) regulations for qualifying coverage and are designed to help pay health-related costs for enrollees. These "qualified plans" provide what the ACA calls minimum essential coverage. Major medical could be an ACA-qualified plan that you purchase yourself through the Health Insurance Marketplace or an insurance company, or coverage through an employer. Major medical plans can provide full coverage with low out-of-pocket costs, but they also can be Catastrophic and other high-deductible health plans as defined by the ACA. Major medical does not include insurance programs like limited benefit plans, fixed indemnity plans, accident supplements or critical illness plans, none of which are regulated by the ACA. What does major medical health insurance cover? Major medical insurance provides coverage for illnesses and injuries, along with preventive care. The ACA requires all major medical plans to cover an extensive list of preventive services for three categories of insureds including adults, women and children. This includes services for immunizations and screenings. Along with preventive services, all major medical plans must provide at least these 10 categories of essential health benefits: Ambulatory patient services Emergency services Hospitalization Maternity and newborn care Mental health and substance use disorder services Prescription drugs Rehabilitative and habilitative services and devices Laboratory services Preventive and wellness services and chronic disease management Pediatric services, including oral and vision care Some states or major medical insurance companies may add coverage such as dental, vision or medical management programs (to help with diabetic needs, for example). How your major medical plan covers these benefits will vary depending on the program you choose. For instance, your coinsurance and deductible amounts along with network restraints play a part in how much you pay. Does major medical insurance allow for preexisting conditions? ACA-compliant major medical insurance does cover preexisting conditions. Under current law, health insurance companies can’t refuse to cover you or charge you more due to a preexisting condition — that is, a health problem you had before the date that your new health coverage starts. All marketplace plans must cover treatment for preexisting medical conditions . No insurance plan can reject you, charge extra or refuse to pay for essential health benefits for any condition you had before your coverage started. Once you are enrolled, the plan can’t deny you coverage or raise your rates based solely on your health. Grandfathered plans — an exception to the preexisting conditions rule The preexisting coverage rule does not apply to "grandfathered" individual health insurance policies. A grandfathered policy is one you bought for yourself or your family on or before March 23, 2010, through an insurance company, agent or broker, that is still active. These plans might not include some rights and protections included in the ACA, including coverage for preexisting conditions. What types of major medical insurance plans are available? There are several types of major medical insurance plans available to individuals and their families, and each is designed to meet different needs. With certain plan types (options sometimes referred to as managed care plans), you are encouraged to use a specific provider network for your care. Others pay more toward services received outside the plan’s provider network. Some examples of ACA-qualified major medical insurance include: Any health plan bought through the Health Insurance Marketplace Individual health plans bought outside the Health Insurance Marketplace, if they meet the standards for qualified health plans Coverage through an employer or a parent's plan Most student health plans Certain veterans coverage The best health insurance plan will be the one that meets your financial and health care needs. Choosing the right health plan is a big decision, so it is important to review your options. Standard major medical insurance The following four plan types are accepted as ACA major medical coverage, as long as they provide the required benefits. They are accessible through the Health Insurance Marketplace, or off-exchange through an insurance company or broker. The plans are location-specific, so not all plans may be available in your area. Exclusive provider organization (EPO): A managed care plan where services are covered only if you use doctors, specialists or hospitals in the plan’s network (except in an emergency). Health maintenance organization (HMO): A type of health insurance plan that typically focuses on prevention and wellness. To help maintain costs, an HMO usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency and may require you to live or work in its service area to be eligible. Point of service (POS): A type of plan where you pay less if you use doctors, hospitals and other health care providers that belong to the plan’s network. POS plans require you to get a referral from your primary care doctor to see a specialist. Preferred provider organization (PPO): A type of health plan where you pay less if you use providers in the plan’s network. You can use doctors, hospitals and providers outside of the network without a referral for an additional cost. Depending on where you live, you may find any or all of these options available to you at each metal level — Bronze, Silver, Gold and Platinum. Major medical Catastrophic health insurance Another category of coverage, called major medical Catastrophic health insurance, is also available through the marketplace. These programs have low monthly premiums but the deductible — the amount you pay before your coverage kicks in — is very high. A Catastrophic plan may be a way to protect yourself from worst-case scenarios, like getting seriously sick or injured, but you’ll pay most routine medical costs yourself. Who is eligible for a Catastrophic plan? Anyone under age 30 may enroll in a Catastrophic plan through the online marketplace. If you are 30 or older, you must qualify for a hardship or affordability exemption to enroll in a Catastrophic plan. The marketplace must confirm, based on the data you provide, that you cannot afford regular health coverage. You usually only qualify during the months of your hardship, plus the month before and the month after the hardship period. However, extensions may be granted for up to a full calendar year. If you are eligible, the available Catastrophic programs will display when you compare plans in the marketplace. What are the costs associated with Catastrophic plans? The monthly premiums for a Catastrophic plan depend on the applicant's situation. Although the premiums are usually low, you can’t use a premium tax credit to further reduce your cost. Before you choose a Catastrophic plan, check to see if you qualify for a premium tax credit based on your income. If so, a Bronze or Silver plan might be a better value. For 2020, the deductible for all Catastrophic plans was $8,150. After you meet the deductible, your insurance company pays for all covered services, with no copayment or coinsurance. What does a Catastrophic plan cover? Catastrophic plans cover the same essential health benefits as other marketplace plans. And, like other plans, Catastrophic plans cover certain preventive services at no cost. They also cover at least three primary care visits per year. These visits are not subject to the deductible. How do I purchase major medical insurance? If you need to buy major medical insurance on your own, you can apply through the Health Insurance Marketplace or your state insurance exchange. Or, you can work directly with an insurance broker or company to purchase an "off-exchange" plan. It is important to remember that while off-exchange major medical plans provide ACA-qualified coverage, they are not eligible for premium subsidies or cost-sharing subsidies. Check first to see if you qualify for either of these benefits before deciding where to purchase your health insurance. To use the marketplace or an insurance exchange, you must live in the United States and be a citizen or a lawfully present resident. You must apply during an open enrollment period, which typically runs from Nov. 1 through Dec. 15 of a given year. You can apply under a special enrollment period if you have a qualifying life event, such as: Losing health coverage Moving Getting married Having a baby Adopting a child Levels of plans in the Health Insurance Marketplace include Bronze, Silver, Gold and Platinum. These "metal levels" are not related to the quality of care but are based on how you and your insurance plan share costs (what your insurance company pays versus what you pay in deductibles, coinsurance or copays). The marketplace will walk you through plans and prices and can provide cost estimates based on your income. You'll also find out whether you qualify for a premium or cost-sharing subsidy. If you prefer to work directly with any of the major medical insurance companies, you can contact them through their respective websites or customer service or sales centers. Major medical insurance plans vs. other insurance: What’s right for me? You may be able to work with a private company to enroll in insurance that does not fall into the category of major medical. Per the ACA, some examples of nonqualified products include: Coverage only for vision or dental care Workers' compensation Coverage for a specific disease or condition Plans that offer only discounts on medical services These limited benefit plans are not regulated by the ACA and do not provide coverage for essential health benefits. So, they generally are not suitable as stand-alone health coverage but can be good add-ons to a major medical plan. Private, limited benefit plans are not required to cover preexisting conditions and may deny or adjust coverage based on an applicant's age or medical history. Fixed indemnity plans This type of medical insurance pays a preset amount on a per-period or per-incident basis, regardless of the total charges incurred. Plans might pay $200 upon hospital admission, for example, or $100 per day while a person is hospitalized. These plans may have annual and lifetime benefit limits and may have specific benefit limits per the type of service. Accident supplement insurance Also known as accident insurance, these policies reimburse you for accident or injury. The policies typically have benefit amounts ranging from $1,000 up to $10,000 or more. Most accident supplements have small deductibles. Critical illness plans A critical illness plan covers a specific disease or condition and pays you a lump sum following the diagnosis of a covered illness. Critical-illness plans cover conditions like cancer, organ transplant, heart attack, stroke, renal failure or paralysis. There is no coverage if you’re diagnosed with a disease that is not on the specific list for your plan, and the list of covered illnesses varies between plans. Benefit amounts can range from $5,000 to $200,000 or more, and premiums are based on the benefit amount and the age of the applicant. Short-term plans These plans offer temporary coverage, generally for a period of 12 months or less. Short-term health insurance can be a good option if you find yourself in a transition such as moving or a job change. Short-term plans often exclude various types of care altogether (for example, prescription drugs, maternity care or mental health care), and they put a cap on the overall amount that the insurance company will pay for a person’s care. Limited benefit plan summary Limited benefit programs can work as temporary coverage or as an add-on to your major medical plan, but they are not intended for use as long-term, stand-alone insurance. You may want to consider these pros and cons of limited benefit plans as you work through your decision.

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