

# Claim Form For Veterinary Fees

## 1 About You - to be completed by policyholder(s)

Policy Number: **DN PET** \_\_\_\_\_

Policyholders' Name Mr/Mrs/Ms \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

*We will make cheques payable to the policyholder shown on your Schedule of insurance.*

*Please indicate here if you require the cheque to be made payable to your veterinary practice* Yes  No

*If yes, please write the practice's name below.* \_\_\_\_\_

## 2 About: Your pet - to be completed by policyholder(s)

Your pet's name \_\_\_\_\_ Male  Female

Breed \_\_\_\_\_ Dog  Cat

If your pet has been seen at more than one veterinary practice, please provide details here.

A. Name \_\_\_\_\_

Address \_\_\_\_\_

B. Name \_\_\_\_\_

Address \_\_\_\_\_

Name of **the illness** or injury you are claiming for (in your own words), and the date when you first noticed any signs.

\_\_\_\_\_ Date \_\_\_\_\_

If your pet has been injured, please use a separate sheet to tell us how it happened.

## 3 Policyholder Declaration - to be completed by policyholder(s)

### Important Points to Note:

- In the case of claims for **REFERRAL** vets please ensure that Allianz has received a **CLAIM** form from the **ORIGINAL** treating vet.
- Do not sign this claim form until it has been **FULLY COMPLETED** (including all dates and treatment costs) by you and the vet, as your claim may be delayed if we do not have this information.
- If we decide that we cannot pay some or all of your claim, you will have to pay your vet for any treatment we have not paid.

Signature of Policyholder **X** \_\_\_\_\_ Date **X** \_\_\_\_\_

Signature of Joint Policyholder **X** \_\_\_\_\_ Date **X** \_\_\_\_\_

Please sign overleaf 

#### 4 About the Illness or Injury - to be completed by the treating Vet

(A) Name of the illness or injury, or state the clinical signs if you have not yet made a diagnosis

\_\_\_\_\_

(B) Has your practice sent us a claim for this illness or injury before? Yes  go to section 5  No or don't know  Referred

(C) When was this pet first registered with your practice? Date \_\_\_\_\_

(D) When did this illness or injury first begin (as noted by you, by the client or on the pet's record)? Date \_\_\_\_\_

(E) If any part of this claim is for dental treatment, please give the dates of the last two annual dental checks (**from the previous two years**), prior to the dental treatment being claimed for

Date \_\_\_\_\_

Date \_\_\_\_\_

Was any dental treatment necessary at this time? Yes  No  If 'Yes', was it carried out at the time? Yes  No

(F) Did you make house visits in connection with the treatment being claimed for? Yes  No

Why were the house visits necessary?

\_\_\_\_\_

(G) If the pet was referred to you, please give the name and address of the referring practice.

\_\_\_\_\_

#### 5 Treatment Fees - to be completed by the treating Vet

(A) First and last date of treatment being claimed for First \_\_\_\_\_ Last \_\_\_\_\_

#### (B) Fees we normally pay for

▼ If the total fees are less than €200, please complete this section. If the total fees are greater than €200 you need to attach an invoice listing dates, treatment and medication for each illness or injury.

Consultations € \_\_\_\_\_

Hospitalisation € \_\_\_\_\_

X-Rays € \_\_\_\_\_

Tests and pathologies € \_\_\_\_\_

General anaesthetic € \_\_\_\_\_

Surgery € \_\_\_\_\_

Medication € \_\_\_\_\_

Other (please give details) € \_\_\_\_\_

#### (C) Total fees

▼ Always fill in this part

VAT (if not already included) € \_\_\_\_\_

Total including VAT € \_\_\_\_\_

#### 6 Vet Declaration

If claiming for illness, or if this is the first time claiming for this condition, please include a Full Clinical History from the first date the pet was registered with your practice.

I have checked the information on this claim form and as far as I know it is correct.

The fees I have charged are no higher than my normal fees.

Practice stamp
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Vet Signature  \_\_\_\_\_

Date  \_\_\_\_\_

Please return to: Allianz, Pet Insurance Claims, P.O. Box 48 48, Freeport, Dublin 4.  
This address may be used on any envelope. It's free and ensures delivery directly to our Claims Staff.  
Telephone: 1890 48 48 48 Fax: 01 660 9453