Southern Cross Health Society

Health insurance claim

After completing this form, please sign and return to: Private Bag 3216, Waikato Mail Centre, Hamilton 3240.
For assistance in completing this form, visit www.southerncross.co.nz/society/forms
If you have any questions call toll free on **0800 800 181**. Calls to this number may be recorded.

Membership number

MEMBER DETAILS Policyholder name and mailing address

Title _____ First name _____ Surname _____ Date of birth _____

Postal address _____
Street number Street Suburb Town/city

Home phone Work phone Extn

Mobile phone E-mail _____

REFUND OPTIONS If we don't have your bank account we will refund by cheque

BANK/BRANCH NUMBER ACCOUNT NUMBER SUFFIX

If your bank account details above are incorrect please update them below

PRIVACY ACT/DECLARATION

This claim form collects personal information about each member named on this form for the purpose of evaluating your claim and for contacting you from time to time (using any of the above contact details) with information about Southern Cross products and services. The intended recipient of this information is Southern Cross Medical Care Society. The information is being collected and held by Southern Cross Medical Care Society, Private Bag 3216, Waikato Mail Centre, Hamilton 3240. If you fail to provide the information requested your claim may be declined. Each member named on this claim form has the right to access and request correction of this information in accordance with the Privacy Act 1993.

This declaration must be signed in order for your claim to be paid

I declare that:

- All of the information supplied on this claim form is complete, true and accurate.
- I am authorised by each member named on this claim form to complete and sign on their behalf.
- This claim is made in accordance with my policy document and the Rules of Southern Cross Medical Care Society.
- I authorise Southern Cross Medical Care Society to obtain from any person or organisation any further information required to evaluate this claim, and I authorise that person or organisation to disclose such information to Southern Cross Medical Care Society.
- I authorise any change of bank account details noted on this claim form.

Policyholder signature _____ **Date signed** ____/____/____

MEDICAL CLAIMS SECTION Please complete on the back of this form

SURGICAL AND CT/MRI CLAIMS SECTION Please attach the original itemised accounts and complete this section

Patient name _____ Date of birth ____/____/____

Name of surgery/procedure _____

Prior-approval number _____ ACC No ☐ ACC Yes ☐ Date of injury ____/____/____

If you wish us to reimburse the provider directly, please tick the Pay provider box.

Procedure	Name of provider/facility	Date of procedure	Amount charged	Pay provider directly?
CT/MRI Scan	Facility _____ Referred by _____			☐
Initial consultation				☐
Surgeon				☐
Anaesthetist				☐
Hospital				☐
Other surgical expenses				☐

Total amount charged _____

MEDICAL CLAIMS SECTION

Please attach the original itemised account(s) and evidence that payment has been made. Attach here in the order listed.

To enable accurate and efficient assessment of this claim, please ensure that you have ☑

- ☐ Checked that the original itemised account(s) includes the following:
  - the date of treatment/service
  - the name of the patient
  - the name of the health services provider who provided the treatment/service
- ☐ Attached the original itemised account(s) and evidence that payment has been made (EFTPOS and credit card receipts without original itemised account(s) are **not** acceptable).
- ☐ Checked that receipts for prescription items show the name of the drug.
- ☐ Checked that the "conditions/symptoms treated" column on this claim form have been completed with the actual conditions/symptoms eg. chest infection. This detailed information is necessary to allow assessment to the cover provided by the policy.
- ☐ Checked that the policyholder has signed the Declaration on the front of this form.
- ☐ Totalled the amount(s) charged at the bottom of this form.

First name of patient	Date of birth	Provider of treatment	Referring provider (if any)	Conditions/symptoms treated – terms such as 'GP visit', 'consultation' or 'check-up' are not acceptable.	Date of treatment	Amount charged
Brian	10/10/1962	Dr Wayne Smith	Dr Grant Jones	tonsillitis	15/01/2010	$80.00
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PLEASE NOTE: ACC related drugs must be claimed directly through ACC.
Claims should be submitted within 12 months of the date of treatment.

Total amount charged _____