Southern Cross Healthcare

Claim Form

After completing this form, please sign and return to: Private Bag 3216, Hamilton.
If you have any questions please call toll free on **0800 800 181**. Calls to this number may be recorded.

Membership number

MEMBER DETAILS
Policyholder name & mailing address

If your mailing address or phone numbers are incorrect or incomplete please update them in the space provided below

Tel No. Home: ( )
Work: ( )
Mobile:
E-mail:

REFUND OPTIONS
(Tick one option only) If neither option is indicated, we will refund by cheque

☐ **Option 1**: Direct credit to bank account ☐ **OR Option 2:** By cheque

BANK/BRANCH NUMBER | ACCOUNT NUMBER | SUFFIX

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

For direct credit refunds, please ensure that the correct bank account details are listed and that you have ticked Option 1.

PRIVACY ACT
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, Hamilton.
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.

DECLARATION
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.
- 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 CLAIMS SECTION
Please complete the section below for surgery performed by a surgeon (Band IV or oral and maxillofacial surgeon). Invoices received without evidence of payment will be paid directly to the treatment provider/facility.

Patient name: Date of birth: / / ☐ Female ☐ Male

Name of surgery/procedure:

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

	Name of provider/facility	Date of procedure	Amount charged
CT/MRI	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 ASSESSMENT OF THIS CLAIM, PLEASE ENSURE THAT YOU HAVE: ☑

- ☐ Checked that the original itemised account(s) lists:
  - 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 for prescription items, the name of the drug is shown on the receipt.
- ☐ 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.
- • Claims should be submitted within 12 months of the date of treatment.

First name of patient	Date of birth d/m/y	Provider of treatment Eg. Dr Wayne Smith	Referring provider (if any) Eg. Your GP, Dr Grant Jones	Conditions/symptoms treated – terms such as "GP visit", "consultation" or "check-up" are not acceptable.	Date of treatment d/m/y	Amount charged
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				TOTAL AMOUNT CHARGED:		

Southern Cross Medical Care Society, 181 Grafton Road, Private Bag 99934, Newmarket, Auckland