

Claim Form

MEMBER DETAILS Policyholder name & mailing address If your mailing address or phono numbers are incorrect or incomplete peace update them in the space provised below Tel No. Home:		use sign and return to: Private Bag 3216, Waikato Mail Co se call toll free on 0800 800 181 . Calls to this number i	,	Membership number			
Mobile: 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 co-account details are listed and that you have toked account details above are incorrect please update them below For direct credit refunds, please ensure that the co-account details are listed and that you have toked account details are listed and that you have toked to the form collects personal information about each member named on this form for the purpose of evaluating your claim and for contacting you from time (using any of the above contact details) with information about southern Cross products and services. The intended register of this information is Societies. The intended register of this information is Societies. The intended register of the purpose of evaluating your claim and provide the information is provided in the provide the information register of your dain may be declined. Each immetry remained on the identification will be information in accordance with the Privacy Act 1993. DECLARATION This declaration must be signed in order for your claim to be paid. I are authorised by each member named on this claim form to complete, true and accurate. I are authorised by each member named on this claim form to complete and slight on their behalf. I are authorised by each member named on this claim form to complete and slight on their behalf. I are authorised by each member named on this claim form to complete and slight on their behalf. I are authorised by each member named on this claim form to complete and slight on their behalf. I are authorised by each member named on this claim form to complete and slight on their behalf. I are authorised by each member named on this claim form to complete and slight on their behalf. I are authorised southern Cros	MEMBER DETAILS						
OR Option 1: Direct credit to bank account	, ,		,				
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 (using any of the above contact details) with information about Southern Cross products and services. The intended recipient of this information is Southern Cross products and services. The intended recipient of this information is Southern Cross Medical Care Society, Private Bag 3216, Walkato Mail Centre, Hamilton 320.1 (you tall 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: - I am authorised by each member named on this claim form is complete, true and accurate. - I am authorised by each member named on this claim form is complete. The fallow of the fulles of Southern Cross Medical Care Society. - I authorise Southern Cross Medical Care Society to obtain from any person or organisation to insuration required to evaluate and sulminosis that person or organisation to accordance such information required to evaluate and sulminosis any further information required to evaluate and sulminosis any change of bank account defails noted on this claim form SURGICAL CLAIMS SECTION Please complete the section below for surgery performed by a surgeon (Band IV or oral and maxillof surgeon). Invoices received without evidence of payment will be paid directly to the treatment provider/facility. Patient name: Date of birth: / / Female	REFUND OPTIONS (T	ick one option only) If neither option is indicated	d, we will refund by ch	eque			
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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 maxillof surgeon). Invoices received without evidence of payment will be paid directly to the treatment provider/facility. Patient name: Date of birth: / / Female Name of surgery/procedure: Prior-approval number: Name of provider/facility Date of procedure Amount charge CT/MRI Facility: Referred by: Initial consultation Surgeon Anaesthetist Hospital	Each member named on the DECLARATION This declaration must be I declare that: • All of the • I am auth • This clair • I authoris and I auth	s claim form has the right to access and request corrections as signed in order for your claim to be paid information supplied on this claim form is complete, true norised by each member named on this claim form to corn is made in accordance with my policy document and the Southern Cross Medical Care Society to obtain from a chorise that person or organisation to disclose such inform	e and accurate. mplete and sign on their be he Rules of Southern Cross any person or organisation a mation to Southern Cross.	ehalf. s Medical Care Soc	iety.		iis claim
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Surgeon Anaesthetist Hospital	CT/MRI	,					
Anaesthetist Hospital	Initial consultation						
Hospital	Surgeon						
	Anaesthetist						
Other surgical expenses	Hospital						
	Other surgical expenses						

☐ Checked that the "conditions/symptoms treated" column on this claim charged Amount Claims should be submitted within 12 months of the date of treatment. ☐ Checked that the policyholder has signed the Declaration on the front eg. chest infection. This detailed information is necessary to allow form have been completed with the actual conditions/symptoms □ Totalled the amount(s) charged at the bottom of this form. TOTAL AMOUNT CHARGED: Date of treatment d/m/y asessment to the cover provided by the policy. Conditions/symptoms treated - terms such as "GP visit", "consultation" or "check-up" are not acceptable. of this form. TO ENABLE ASSESSMENT OF THIS CLAIM, PLEASE ENSURE THAT YOU HAVE: Checked that for prescription items, the name of the drug is shown on the receipt. - the name of the health services provider who provided the treatment/service has been made (EFTPOS and credit card receipts without original itemised Attached the original itemised account(s) and evidence that payment Referring provider (if any) Eg. Your GP, Dr Grant Jones ☐ Checked that the original itemised account(s) lists: account(s) are **not** acceptable). - the date of treatment/service Provider of treatment Eg. Dr Wayne Smith - the name of the patient Date of birth d/m/y MEDICAL CLAIMS SECTION **EVIDENCE THAT PAYMENT HAS** PLEASE ATTACH THE ORIGINAL ITEMISED ACCOUNT(S) AND **BEEN MADE. ATTACH HERE** IN THE ORDER LISTED. First name of patient