Southern Cross
Health Society

Health insurance claim
assisted by provider

After completing this form, have policyholder sign and return to:
Private Bag 3216, Waikato Mail Centre, Hamilton 3240, Freepost Authority 15817.
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 ______________________

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

BANK/BRANCH NUMBER ACCOUNT NUMBER SUFFIX

PRIVACY ACT/DECLARATION

This claim form collects personal and health information about each member named on this form for the purposes set out in the Southern Cross Medical Care Society Privacy Statement, including evaluating your claim, preventing, detecting and investigating fraud, and 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, Freepost Authority 158217. 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 their information in accordance with the Privacy Act 1993. The full Southern Cross Medical Care Society Privacy Statement is available at www.southerncross.co.nz/privacy.

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 (including health care providers) any further information reasonably required to evaluate and investigate this claim (including after payment), and I authorise that person or organisation (or health care provider) 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 AND SURGICAL 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	Conditions/Symptoms treated	Date of procedure	Amount charged	Pay provider directly?
CT/MRI Scan	Referred by ____________			☐
Surgeon				☐
Anaesthetist				☐
Hospital				☐
X-ray				☐
Consultation				☐
Consultation				☐
Other expenses				☐
Other expenses				☐
Other expenses				☐

Total amount charged ____________

PLEASE NOTE: ACC related drugs must be claimed directly through ACC.
Claims should be submitted within 12 months of the date of treatment.

* Please complete member refund section if this claim is not being paid directly to the provider.