



For faster claiming and reimbursement use My Southern Cross or our app - visit [schs.nz/app](http://schs.nz/app)



If you've seen an **Easy-claim provider** or an **Affiliated Provider** they'll take care of your claim for you, so you don't need to use this form

Policy number

## POLICYHOLDER DETAILS We'll update your contact details in our system if you make changes here

First name \_\_\_\_\_ Surname \_\_\_\_\_ Date of birth \_\_\_\_\_

Postal address \_\_\_\_\_

Street number

Street

Suburb

Town/city

Home phone

Work phone

Extn

Mobile phone

E-mail

## YOUR BANK ACCOUNT DETAILS FOR PAYMENT If you have paid for your treatment

BANK/BRANCH NUMBER

ACCOUNT NUMBER

SUFFIX

## SURGICAL CLAIMS We need the receipt or invoice from your **surgeon** before we can process any part of your claim

Patient name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of surgery/procedure \_\_\_\_\_

Prior approval number \_\_\_\_\_ ACC related? No  Yes  If yes, date of injury \_\_\_\_/\_\_\_\_/\_\_\_\_

Procedure	Name of provider/facility	Date of procedure	Amount charged
Surgeon			
Anaesthetist			
Hospital			
Other expenses			
Other expenses			
Other expenses			

Do you want us to pay your provider directly?

No  Yes

No  Yes

No  Yes

No  Yes

No  Yes

No  Yes

Total amount charged \_\_\_\_\_

If you want us to pay your provider directly please indicate in the pay provider section above. We already have their account details so you don't need to provide them on this form.

## 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 Member 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 Group 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 their information in accordance with the Privacy Act 1993. The full Southern Cross Medical Care Society Member Privacy Statement is available at [www.southerncross.co.nz/privacy](http://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 it on their behalf.
- This claim is made in accordance with my policy document.
- I authorise Southern Cross Medical Care Society to obtain from any person or organisation (including healthcare providers) any further information reasonably required to evaluate and investigate this claim (including after payment), and I authorise that person or organisation (or healthcare provider) to disclose such information to Southern Cross Medical Care Society.
- I authorise any change of the bank account details used for claims payment, if the bank account details entered on this claim form are different to previous claims.

**SIGN HERE**

Policyholder signature \_\_\_\_\_ Date signed \_\_\_\_/\_\_\_\_/\_\_\_\_

After completing and signing this form, please return to: Southern Cross Health Society, Private Bag 3216, Waikato Mail Centre, Hamilton 3240.

If you have any questions call us on 0800 800 181. Calls to this number may be recorded.

