Southern Cross Health Insurance

Health insurance claim

For faster claiming and reimbursement use My**SouthernCross** or our app – visit **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

Southern Cross Medical Care Society (the Society) may collect personal information shared in this form, as well as from other sources (including from brokers, previous insurers, reinsurers, employers and healthcare professionals) in relation to this form. Any personal information will be collected (whether from you or from a third party) in accordance with the purposes listed in the Society's Privacy Statement. The information will be collected and held by Southern Cross Medical Care Society, Level 1, Te Kupenga, 155 Fanshawe Street, Auckland City 1010, New Zealand. If you do not provide the information requested, your claim may be declined. You have the right to access and request correction of the information in accordance with the Privacy Act 2020.

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 understand that any false or incorrect information I provide may result in this claim being declined and/or my policy being cancelled in accordance with its terms.
- 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. Freepost Authority Number 1440 NZ. If you have any questions call us on 0800 800 181. Calls to this number may be recorded.

MEDICAL CLAIMS

First name of patient	Date of birth	Provider of treatment/service	Referring provider (if any)	Conditions/symptoms treated eg. chest infection	Date of treatment	Amount charged
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Total amount charged _____

CHECKLIST

Please attach the original itemised receipts or invoices and evidence that payment has been made, if you have already paid.

To help us assess your claim, please check that:

- ☐ your receipt or invoice includes the following:
  - the date of treatment/service
  - the name of the patient
  - the name of the healthcare provider who provided the treatment/service
- ☐ you have attached the original receipts and evidence that payment has been made if you have already paid (an EFTPOS or credit card receipt by itself is not acceptable)
- ☐ receipts for prescription items show the name of the drug
- ☐ the Conditions/symptoms treated column on this form has been completed correctly, with the actual condition or symptom that was treated
- ☐ the Declaration on the front of the form has been signed by the policyholder
- ☐ you've totalled the amount charged