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	Do you want us to pay your provider directly?
Surgeon				No ☐ Yes ☐
Anaesthetist				No ☐ Yes ☐
Hospital				No ☐ Yes ☐
Other expenses				No ☐ Yes ☐
Other expenses				No ☐ Yes ☐
Other expenses				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 2020. The full Southern Cross Medical Care Society Member 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 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
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	
	/ /				/ /	

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