Claim form

taking care
accuro health insurance

1 Please complete the details for the main member

Membership number	
Title	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other (please specify):
First name(s)	
Surname	
Postal address	Street
	Town/city Postcode
Telephone	Home ( )
	Business ( )
	Mobile
Email	

2 Refund Direct credit to member's bank account

Bank account number	☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐

◯ I authorise information about the details of this claim to be provided to my adviser.

OFFICE USE ONLY

Date DD / MM / YY	Claim number	Entered by

Paid to	Amount	Plan/excess	Authorised by	Authorisation date	Print cheque	Direct credit?
	$			DD / MM / YY	◯ Yes ◯ No	◯ Yes ◯ No
	$			DD / MM / YY	◯ Yes ◯ No	◯ Yes ◯ No
	$			DD / MM / YY	◯ Yes ◯ No	◯ Yes ◯ No
	$			DD / MM / YY	◯ Yes ◯ No	◯ Yes ◯ No
	$			DD / MM / YY	◯ Yes ◯ No	◯ Yes ◯ No
	$			DD / MM / YY	◯ Yes ◯ No	◯ Yes ◯ No
	$			DD / MM / YY	◯ Yes ◯ No	◯ Yes ◯ No
	$			DD / MM / YY	◯ Yes ◯ No	◯ Yes ◯ No
	$			DD / MM / YY	◯ Yes ◯ No	◯ Yes ◯ No

Please refer to your membership certificate and the Accuro Health Insurance general terms and conditions for your policy exclusions.

3 Surgical claims Please attach the itemised accounts and complete this section

Pre-approval number	
Patient name	

Procedure	Name of provider/facility	Date of procedure	Pay provider directly	Amount charged
		DD / MM / YY	◯ Yes ◯ No	$
		DD / MM / YY	◯ Yes ◯ No	$
		DD / MM / YY	◯ Yes ◯ No	$
		DD / MM / YY	◯ Yes ◯ No	$
Total amount charged				$

4 Medical claims

Important information: To enable accurate and efficient assessment of this claim, please ensure that you have:

- ◯ Checked that the itemised account(s) includes:
  - the date of treatment/service
  - the name of the patient
  - the name of the health services provider who provided the treatment/service.
- ◯ Attached a GP referral letter and/or specialist letter (if applicable).
- ◯ Attached a medical report (for members for less than five years).
- ◯ Attached the itemised account(s) and evidence that payment has been made (EFTPOS and credit card receipts or statements without itemised account(s) are not acceptable).
- ◯ Checked that receipts for prescription items show the name of the drug.
- ◯ Checked that the 'Full details of nature of illness or treatment received' column on this claim form has been completed with the actual condition/symptoms, e.g. chest infection.
- ◯ Checked that the main member has signed the declaration below.
- ◯ Checked that claims have been submitted within 12 months of the date of treatment.
- ◯ Checked that any optical claims have been endorsed and itemised by the optometrist with confirmation that the spectacles or contact lenses are necessary because of a change of vision.

5 Declaration/Privacy Act

This claim form collects personal information about you and those covered under your plan for the purpose of evaluating your claim. The intended recipient of this information is Accuro Health Insurance. The information is being collected and held by Accuro Health Insurance, PO Box 10075, Wellington. Failure to provide the information requested may result in your claim being declined. You have the right to access and request correction of this information in accordance with the Privacy Act 1993.

This declaration must be signed in order for your claim to be paid.

I declare that all particulars shown on this form are true and correct, that this claim is made in accordance with the conditions of my membership and that Accuro Health Insurance is hereby authorised to obtain copies of any medical records that they may require. I declare that this claim is made in accordance with my policy document and the Rules of Accuro Health Insurance.

Main member signature DD / MM / YY

Please refer to your membership certificate and the Accuro Health Insurance general terms and conditions for your policy exclusions.

Details of claims

First name of patient	Date of treatment	Treatment provider	Full details of nature of illness or treatment received	Amount charged
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
Total amount claimed				$

Please refer to your membership certificate and the Accuro Health Insurance general terms and conditions for your policy exclusions.

Details of claims

First name of patient	Date of treatment	Treatment provider	Full details of nature of illness or treatment received	Amount charged
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
Total amount claimed				$

Level 1 | 79 Boulcott Street | PO Box 10075 | Wellington 6143 | New Zealand | Freephone 0800 ACCURO (0800 222 876) | Email info@accuro.co.nz
Facsimile 04 473 6187 | facebook.com/Accurohealthinsurance | **www.accuro.co.nz**