Claim and Pre-approval

nib

1.0 About your policy

Policy number

Contact details (policyowner)

Name

Phone ( )

Mobile ( )

Fax ( )

Email

Address details

Street / Box number

Street name

Suburb

Town / City

Postcode

Please answer the applicable sections fully before you date and sign this form. If you need assistance in completing this form please phone us on 0800 123 nib (0800 123 642) or visit nib.co.nz

1.1 Please tick one of the boxes below, indicating what type of health claim you are making

- ○ **Pre-approval request** for surgery, private hospitalisation, chemotherapy, radiation therapy, diagnostic investigation (including CT and MRI) and / or specialist consultation. (Please complete sections 1.0, 2.0, 3.0, 3.1 and 6.0) (PAF)
- ○ **Payment request for a claim that has been pre-approved**. Please attach the Pre-approval letter to the invoices and submit or supply pre-approval number here: and complete sections 1.0, 4.0 and 6.0 (HCFD)
- ○ **Payment request for a claim that has NOT been pre-approved** for surgery, private hospitalisation, chemotherapy, radiation therapy, diagnostic investigation (including CT and MRI), and / or specialist consultation. (Please complete sections 1.0, 2.0, 3.1, 4.0 and 6.0) (HCFUS)
- ○ **Payment request** for GP, dental, optical or other **medical expenses. (Please complete sections 1.0, 4.0 and 6.0) (OHCF)**
- ○ **Payment request** for a specialist consultation (not related to surgery). (Please complete sections 1.0, 3.1, 4.0 and 6.0) (OHCF)

Note: For pre-approvals, please ensure your GP referral and specialist letter are attached.
Please note there will be a delay in processing your claim if all relevant sections are not completed.

2.0 About your claim (to be completed by the patient)

Name of patient (insured person)

Date of birth d d m m y y y y

Proposed treatment / operation / diagnostic investigation

Proposed date d d m m y y y y

Proposed length of hospital stay (number of days) d d d

Day stay? ○ Yes ○ No

Do you have any other insurance policy you could claim against? ○ Yes ○ No

If "Yes", please give details, including policy number.

Note: You must attach a copy of your specialist consultation letter and the quotation for the treatment / operation / diagnostic investigation.

3.0 About the pre-approval cost

Note: Please attach quotes obtained.

Treatment / operation / diagnostic investigation costs as quoted by your specialist

Provider / service	Cost	Name of Hospital and Specialist
Specialist	$	
Anaesthetist	$	
Radiology (i.e. MRI scan, CT scan)	$	
Prosthesis	$	
Hospital costs	$	
Other	$	
Total procedure cost		

3.1 Medical report (to be completed only by your usual family doctor, GP, dentist or optometrist)

☐ Please attach a copy of the Referral Letter to the Specialist
☐ Please also attach any supporting documentation stating when symptoms or signs of this health condition first became apparent to you

Current doctor's details

Doctor's name
Phone ( )
Fax ( )
How long have you attended him / her?
Doctor's address
Street name and number
Suburb
Town / City
Postcode

Previous doctor's details (if known)

Doctor's name
Phone ( )
Fax ( )
How long did they attend him / her?
Doctor's address
Street name and number
Suburb
Town / City
Postcode

Patient details

Patients Surname		Given Name(s)	

What is the underlying health condition that made the surgery / treatment / diagnostic necessary?

What was the date the patient first noted the symptoms?

What was the date the patient first sought investigation or medical advice?

Please provide details of any subsequent consultations / investigation / treatment / surgery including dates.
(Please also provide copy of GP referral letter and first consultation letter)

If the patient has required surgery / treatment / investigations for this or a similar condition before, please provide details including dates.

Is this condition ACC related? Please attach the ACC Acceptance / Decline Letter	◯ Yes ◯ No
Please attach a histology report, if applicable, regarding the above health condition	◯ Attached

Authorised Signature

Family doctor / GP, dentist or optometrist

Full name	**Date**	**Signature**
	d d m m y y y y	

3.2 About your representative (if applicable – to be completed by the insured person)

I give my authority for any details of this claim to be provided to

My adviser ◯ Yes ◯ No

Adviser's name

Or:

Contact details

Name and relationship to patient
Home phone ( )
Mobile ( )
Fax ( )
Email

Address details

Street number
Street name
Suburb
Town / City
Postcode

4.0 Refund for all types of claims (to be completed by the insured person)

Important notes:

- Claims must be supported by the original itemised accounts and receipts (not copies) showing the name of the patient, date of consultation, description of services; as well as the name, qualification and GST number of the provider of the service. Pharmacist receipts must show the name of the patient, prescription number and name of the medication prescribed and the cost of each item.
- Please ensure that all accounts and receipts are submitted to nib nz limited, within 12 months of incurring the cost. Claims must be submitted within 30 days after the termination of the policy.
- If you require more space to provide the details below, please complete the details on a separate sheet, attach it to this claim form and ensure you include your policy number on the separate sheet.

First name of insured person	Date of treatment	Name of provider	Reason for service / item provided	Amount	If refund is to you directly, please indicate below
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
				$	☐
			Total Claim	$	

5.0 About your refund (to be completed by the policyowner(s)

We pay claim refunds by direct credit into your nominated bank account. Please attach a deposit slip or fill in details below. Please print clearly. If a claim is accepted, refunds can not be paid when a policy premium is in arrears unless the policyowner(s) have provided authority to deduct any outstanding premiums from any claims payment.

5.1 Bank account details

Name on account

Account number

Name of bank

Name of branch

6.0 Important information and declaration (to be completed by the policyowner(s) and the patient)

Duty of Disclosure

You and anyone else named in this claim form must tell us everything you know (or ought to know) which would influence the decision of a prudent insurer whether to accept this claim, and if so, on what terms. When in doubt, disclose.

Privacy Act 1993 and Health Information Privacy Code 1994

nib is collecting information about you or anyone named in this form to evaluate, administer and assess your benefits. We may be required to collect information from or disclose an insured person's personal information to:

- Other nib companies.
- Your financial adviser.
- Health service providers including private health insurers, recognised private hospitals and public hospitals, doctors and medical specialists, and professional medical authorities, including the ACC and the Ministry of Health.
- Our contractors and service providers performing services including (but not limited to) legal services, mail house services and product development services.
- Our existing and future strategic partners in respect of co-branded covers and services.

You have the right to access and correct your personal information under the Privacy Act 1993 and the Health Information Privacy Code 1994. If you believe that any personal information we hold is not accurate, complete or up-to-date, you should contact us immediately. The information is being collected and held by nib whose contact details are set out at the bottom of this page.

All information is true and correct

Each policyowner and insured person signing below declares that all information given by them is true, correct and complete. If it is not, we may, at our discretion, cancel this policy from the commencement date, effective date or join date (as applicable). If we cancel this policy, any premiums paid may be retained by us. If we have already made any claims payments, we may recover these from the policyowner.

If you have provided information on behalf of another person, you confirm that you are authorised to do so.

Signature

Before signing please ensure that you have answered all the questions and have read and understood the 'Important information and declaration' above.
Note: To be signed on behalf of a patient under age 16 by the patient's parent / legal guardian.

Full name	Date	Signature
Patient name	d d m m y y y y	
Policyowner (if different)	d d m m y y y y	

6.1 Important reminders

- Please ensure you have completed all the relevant sections, and signed and dated section 6.0.
- Please note that completion and submission of this form is not an acceptance of your claim.
- For payment requests, please supply original invoices.

Please send this form to: nib nz limited, PO Box 91 630, Victoria Street West, Auckland 1142, Phone: 0800 123 nib (0800 123 642),
For pre-approval only Fax: 0800 345 134, Email: claims@nib.co.nz