Claim form

accuro HEALTH INSURANCE

1 Details of main member/guardian

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

2 Refund Direct credit to member/guardian's bank account

Bank account number	

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

3 Pre-approved claims Please complete this section if you have already obtained approval for the procedure

Pre-approval number	
Patient name	

Procedure name	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	$
		DD / MM / YY	◯ Yes ◯ No	$
Total amount charged				$

If you are claiming for a procedure, treatment or consultation that has not been pre-approved, then please carry on to Section 4 on the next page

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

4 Medical claims

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

- ◯ Checked that the itemised account(s) includes:
  - » the date of treatment/service
  - » the name of the patient
  - » the name of the health service provider who provided the treatment/service.
- ◯ Attached a GP referral letter and/or specialist letter (if applicable).
- ◯ Attached a completed Accuro medical report form (for members/children with cover 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 sufficient).
- ◯ 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/guardian has signed the declaration below.
- ◯ Checked that claims have been submitted within 12 months of the date of treatment.

5 Declaration/Privacy Act

This claim form collects personal information about you and those covered under your policy 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 and those covered by your plan have the right to access and request correction of this information in accordance with the Privacy Act 1993.

This declaration must be signed by checking the box below 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 the medical records of the person, to which this claim relates, 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/guardian signature ☐ Date signed: 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

Please note, that if you do not attach confirmation of payment or a receipt with an invoice, we will make payment of the invoice directly to the provider unless this is under a reimbursment only plan.

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			$
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	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 continued

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			$
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	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
	DD / MM / YY			$
Total amount claimed				$