How to apply for pre-approval

Pre-approval is when we confirm cover under your policy before your procedure or medical treatment (such as a surgery) happens. We'll also tell you of any conditions or excess that may apply. We need 2 working days to process pre-approvals.

Pre-approval is required:

- for any procedure or medical treatment that is likely to cost $1,000 or more
- if your procedure or medical treatment requires hospitalisation, day-stay, or in-patient care.

If in doubt, get pre-approval. If you don't get pre-approval, we may not be able to approve your claim.

Collect a pre-approval form

You'll need to complete a pre-approval form. You can find the form on our website, in the online member portal, or we can post or email a copy to you. The main member must sign this form, and so must the patient if they are over 16 years of age.

Get an estimate of the cost

Ask your health service providers and the hospital for an estimate of the cost for the procedure or medical treatment. Please try to get an estimate of the cost for all parts of your procedure and treatment. Include the number of nights in hospital, theatre fees, and any additional costs such as equipment and physiotherapy. This information allows us to make sure the full cost will be covered. We understand that the information you get will be an estimate and the actual costs may vary.

If the cost is above what we judge to be a reasonable cost for the type of procedure or medical treatment (our reasonable and customary charges), we may ask for further information or we may recommend an alternative treatment or health service provider.

If you choose to continue at the previous cost, you'll need to pay the difference between the amount we approve and the actual cost of the procedure or medical treatment, regardless of the benefit's maximum limit.

You'll need to let us know if another insurer, including ACC, has a responsibility to pay for all or part of the procedure or medical treatment.

Provide medical evidence

You and all participants on your policy must give us all the information we reasonably need to assess your pre-approval or claim. We're entitled to ask for information from the pre-approval process, up to and following a claim being made.

You'll need to provide some *medical evidence* for why the procedure or medical treatment is required, so that we can make sure it's covered under your policy. This medical evidence could be either a copy of the GP referral letter or a letter from the specialist that confirms why the treatment is needed.

You may also need to ask the GP who holds the patient's medical history to complete Accuro's Medical report. We'll need this report if:

- the patient having the procedure or medical treatment is within the first 5 years of their policy, and
- this is the first time the patient is claiming for this medical condition.

Please see the 'Why do you need to provide medical evidence' section on page 25 for further information.

You'll need to pay for any costs associated with getting medical evidence.

Submit your pre-approval

You can submit your pre-approval by post or email, or through the online member portal. In some cases, we may need to contact you or the health service providers to request additional details to make sure we assess your pre-approval correctly. We'll contact you if this is the case.

Please call or email us if you're unsure about how to apply for pre-approval, including whether or not you need to supply a Medical report.

Why do you need to provide medical evidence?

We need medical evidence to confirm that the service you are claiming for is covered under your policy. We need medical evidence to assess a claim or pre-approval.

Medical evidence could either be a copy of the referral letter, or consultation notes from the GP, dentist or optometrist. We would also accept a copy of the specialist's letter or notes confirming the outcome of your consultation or treatment.

The medical evidence must be from the medical professional who saw the patient for the condition. It must state why the consultation, procedure or treatment is, or was, required.

When do we need a Medical report?

You need to provide a Medical report form with your claim or pre-approval if:

- you did not provide your complete medical history at the time of submitting your application to Accuro (that's all your medical notes from birth to the date you applied for health insurance with Accuro), and
- you're claiming within the first 5 years of your Hospital & Surgical+ base plan or Specialist+ plan, and
- you have not claimed for this condition before.

The Medical report form needs to be completed by the GP (or dentist or optometrist) who holds your medical history. We need this form to give us the history of the condition, its symptoms, and when it first became apparent. Often the GP referral or specialist letter will not give us a comprehensive history of the condition, which is why we ask for the Medical report form to be completed.

You must pay any costs involved in getting any of the information above.

Things to remember

We can only accept and provide cover for costs:

- for a person who is covered under your policy
- for events that occur after your policy begins
- under a policy that has premiums paid up to date
- for benefits listed in the plans you have cover for
- charged at a reasonable and fair cost (within our reasonable and customary charges)
- for services only in the private sector (unless listed otherwise in your policy document).

We recommend that you read the next section ('What we will pay'), as things listed here may affect your claim or the amount we're able to pay out for a particular procedure or medical treatment.

Please call or email us if you're unsure about anything, including whether you need to send a Medical report with your claim.