Form - PH 01

HEALTHCARE 99 REQUEST FOR PRE-APPROVAL OF TREATMENT COSTS

PLEASE COMPLETE ALL SECTIONS AND RETURN TO:
Healthcare 99, PO Box 74301, Green Lane, Auckland 1546

Name of Member ____________________ Date of Birth ____________

Patient Name ____________________ Healthcare 99 Membership Number ____________

Address ____________________

City ____________ Postcode ________ Phone Contact Number ____________

Email ____________________

Healthcare 99 is a mutual fund not an insurance scheme

Is this covered by ACC/AES? YES/NO

PLEASE SUPPLY A LETTER OF REFERRAL FROM GP/SPECIALIST

HOSPITALISATION

Name of Hospital ____________________ *Date of Treatment* ____________

Estimated Total Cost $ ____________

Hospital

Room Costs $

Theatre $

Prosthesis/implants $

Sundry Expenses $

Surgeon

Operation $

Pre/Post Surgery Consultations $

Anaesthetist

Operation $

Pre/Post Surgery Consultations $

DIAGNOSIS AND TREATMENT

Diagnosis ____________________

Proposed Treatment ____________________

Southen Cross schedule code number ____________

SURGEON DETAILS

Name ____________________ Phone ____________

Address ____________________

OFFICE USE ONLY

Has claim been approved? YES NO Date ____________

____
Signature

17/10/19

Privacy Statement

This document collects personal information about you so the New Zealand Firefighters Society can consider your claim.

The information is received and held by the New Zealand Firefighters Welfare Society, Private Bag 31999, Lower Hutt 5040.

You may request access to, and correction of, this information according to the provisions of the Privacy Act 2020.

I declare to the best of my knowledge the details given in this claim form are true.

I agree that the New Zealand Fire Fighters Welfare Society may give or obtain from appropriate individuals or organisations information relevant to evaluate and administer this claim.

With regard to any injury or illness, I hereby authorise any hospital, physician or other person who has attended me to furnish the New Zealand Firefighters Welfare Society, or its representatives, with any and all information with respect to any medical history, consultation, prescription or treatment and copies of all hospital or medical records.

I agree that an electronic version of this authorisation shall be considered as effective and valid as the original and that electronic invoices submitted are copies of the original invoices (please retain the original invoices in case we require them later).