PRE-APPROVAL CLAIM FORM

Pre-approvals are designed to **pay the medical provider directly on your behalf** for claims over $500.00.
If you prefer to pay for the investigation/treatment yourself, please do not apply for pre-approval. Please contact us if you want to confirm if a procedure is covered.

Accident-related claims (ACC) including surcharges and any associated costs are not covered by the policy

1.0 MEMBER DETAILS

FULL NAME _____

ADDRESS _____

CONTACT PHONE_____ EMAIL_____

2.0 CLAIMANT DETAILS – Each person submitting a claim will need to complete their own claim form

CLAIMANT NAME: _____ DATE OF BIRTH _____

3.0 CLAIM DETAILS

DATE OF ADMISSION _____Please allow 5 working days for assessment

MEDICAL CONDITION/SYMPTOMS REQUIRING INVESTIGATION/TREATMENT e.g., chest pain, cancer

_____

_____

TREATMENT REQUIRED e.g., CT Scan, Colonoscopy

_____

SURGEON/SPECIALIST _____ HOSPITAL/FACILITY _____

4.0 CHECKLIST

- ☐ Fully completed claim form
- ☐ GP Referral letter/Specialist report recommending the investigation or treatment
- ☐ Estimate of Costs for all providers e.g., Surgeon, Hospital, Anaesthetist

*Failure to provide the above may result in a delay of the assessment of your claim

5.0 CLAIM SUBMISSION

Email: nz.healthcare99@gbtpa.co.nz
Online: www.healthcare99.org.nz
Post: Healthcare 99
P O Box 74301
Greenlane
Auckland 1546
Phone: 0800 653 473 Option 2
*We highly recommend claims to be emailed or completed online due to delays in receiving mail, and periods of working from home due to the pandemic and other unforeseen circumstances.

6.0 DECLARATION & CONSENT – Please read and sign this declaration

I declare that all medical information pertaining to me or the claimant and relevant to my insurance claim has been provided and disclosed to the NZ Firefighters Welfare Society. I understand that making any false or fraudulent claim may result in the cancellation of my policy and I may have to repay any claims.
I further understand that the medical information provided is the basis on which the Firefighters Welfare Society will assess and manage my claim. I have fully disclosed all relevant information in good faith. I understand that failure to provide this information may result in my claim being declined or unable to be assessed. I declare all answer on this form to be true and correct

CLAIMANT NAME _____CLAIMANT SIGNATURE _____

DATE _____