Claim form.

UniMed

If your policy number starts with PL, this is your form.

This form is for Members on SmartCare, SmartCare+, StaffCare, StaffCare+, SmartStay and other Health Plans or group insurance schemes originally issued under the Accuro brand.

For the fastest processing and reimbursement, please claim online through your Member Portal. Just login or register at unimed.co.nz/claims.

If you can't submit online, email your form to myclaim@unimed.co.nz.

Any field marked by an asterisk (*) is mandatory and must be completed in all cases.

1. Details of Primary Member/ guardian

Full name*

First name(s)

Last name

Membership/ policy number

Date of birth* (dd/mm/yy)

Address*

Email

Phone number

UniMed pays your claim reimbursement directly to your bank account, so...

- If you have already provided us with your bank account details, tick **'Use my current bank details'**.
- Or, if your bank account details have changed please tick **'Add or update my bank details'**.

My bank account details*

- ○ Use my current bank account details
- ○ Add or update my bank account details:

Name on account (e.g. John Smith)

Bank name (e.g. ANZ, BNZ, Westpac)

Account number

Please refer to your Membership/ Policy Certificate and your Health Plan terms and conditions for policy exclusions.

2. Claims with prior approval

Please complete this section if you have already obtained approval for the medical treatment or procedure.

If you are claiming for a procedure, treatment or consultation that does not have prior approval, then please carry on to Section 3.

Prior approval number

Patient name

Procedure name	Name of provider/ facility	Date of procedure (dd/mm/yy)	Pay provider directly?	Amount charged
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	

Total amount charged: $ 0.00

3. Details of all claims

Please ensure you complete all details clearly, including the actual condition/ symptoms (e.g. chest infection) and attach:

- the receipt or invoice issued by your healthcare provider or facility, showing the Member/ patient name, date of treatment, description of service, qualification and GST number of provider
- a GP referral letter and/ or specialist letter (if applicable)

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 claim is under a reimbursement-only Plan.

More claim lines are available on Page 4. Need help? Please see unimed.co.nz/claims.

	Date of visit (dd/mm/yy)	Name of patient (in capitals please)	Name of doctor/ practitioner	Nature of illness/ treatment received	Amount paid/ invoiced
1					
2					
3					

Total claim amount: $ 0.00

4. Declaration and authorisation

The personal and health information about you and those covered under your Health Plan is collected for the purpose of evaluating your claim.

Please refer to our Privacy Statement for more information about how your information will be used, our privacy practices, and your associated rights – unimed.co.nz/privacy.

Failure to provide the information requested may result in the claim being declined.

Are the events under this claim eligible for reimbursement from another health insurer or ACC?

◯ Yes ◯ No

☐ I declare all information provided in this form is true, correct and complete and that I have not omitted or misrepresented any information.

☐ If this form includes information about another person, I confirm that they have authorised me to submit this form on their behalf and they understand the information I provide will be shared with UniMed.

I authorise all information and documents about this claim to be shared with my Adviser:

◯ Yes ◯ No ◯ Not applicable

Signed*

Primary Member full name	Signature	Date (dd/mm/yy)

Details of all claims continued

	Date of visit (dd/mm/yy)	Name of patient (in capitals please)	Name of doctor/ practitioner	Nature of illness/ treatment received	Amount paid/ invoiced
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					