Medical report.

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.

UniMed is not liable for any costs associated with the completion of this form. It is to be signed by the Member/ patient and then completed and signed by the patient's usual GP/ dentist.

Complete and return to us at myclaim@unimed.co.nz.

Patient's full name

First name(s)

Last name

Policy number

Patient's date of birth (dd/mm/yy)

1. Patient Declaration

THIS DECLARATION IS VERY IMPORTANT. PLEASE ENSURE YOU READ IT CAREFULLY.

UniMed needs to know relevant aspects of your current and historic health to evaluate your claim or prior approval request under the terms of your policy.

The information is used to assess to what extent we can cover your claim or prior approval request, including assessing whether your symptoms are related to a pre-existing condition.

The health information provided might also be used by UniMed for updating your policy and assessing future claims or prior approval requests.

You are entitled to request access to the health information UniMed holds about you and to request corrections if you believe the information we hold about you is incorrect.

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

Declaration

☐ In providing this form to my General Practitioner or Dentist (Practitioner), I consent for UniMed to receive my health information from my Practitioner and for my Practitioner to release this information to be used for the above purpose.

Please select one:

◯ I request that my Practitioner send this form directly to UniMed at myclaim@unimed.co.nz.

OR

◯ I request that my Practitioner send this form back to me. I will send it to UniMed at myclaim@unimed.co.nz.

Patient's full name

Patient's (or guardian's) signature

Date signed (dd/mm/yy)

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE PATIENT'S GENERAL PRACTITIONER OR DENTIST.

2. GP/ dentist's details

NOTE TO THE PATIENT'S GP/ DENTIST

The below patient is claiming a benefit from UniMed, and we require the information from you, as the registered medical practitioner for the patient, in order to assess this claim as quickly as possible. Thank you for your assistance. If extra space is required, please attach a separate sheet.

GP/ dentist's name

GP/ dentist's address

Are you the patient's usual GP/ dentist?

Yes No

If 'No', please provide the usual GP/ dentist's name and address

Do you hold the patient's full medical/ dental history?

Yes No

Please indicate what years the history spans

3. Medical history

Please provide a complete description of the condition

What is the proposed treatment?

In your opinion, when were signs and/ or symptoms first present?

What date was medical advice first sought?

Does the patient have a history of, or predisposition to, this condition?

Has the patient been seen by any other doctor/ hospital/ clinic in relation to this condition?

4. ACC (if applicable)

Is this an ACC-related condition?

Yes No

If yes, has a claim for this condition been lodged with ACC?

Yes No

If yes, has ACC accepted cover for this condition?

Yes No

Note: Please attach any ACC acceptance or decline documents

Note to Primary Member: Our terms and conditions require you to seek cover through ACC first if this relates to a personal injury. If ACC declines your claim, you can then apply for cover under your UniMed policy.

5. Declaration by GP/ dentist

Has this form been completed in full with all questions answered?

◯ Yes ◯ No

☐ I declare that, to the best of my knowledge, the information I have provided in this form is true, correct and complete and that no information relevant to the patient's symptom(s), condition(s) or diagnosis(es) has been omitted from this form.

☐ I declare that I am registered as a medical practitioner with the Medical Council of New Zealand or Dental Council of New Zealand and am not the patient, the Primary Member or either of their respective partners or relatives.

GP/ dentist's signature

Date signed (dd/mm/yy)

PLEASE RETURN THIS FORM TO EITHER THE PATIENT OR TO UNIMED AS DIRECTED BY THE PATIENT IN THE DECLARATION SECTION ON PAGE 1.