

Critical diagnosis claim.



This form is for Members with Critical Diagnosis cover as part of their group insurance scheme.



Please complete this form in support of your critical diagnosis claim. To assist in processing your claim, we require information relating to the health condition for which you're claiming the critical diagnosis benefit, including supporting evidence from your medical practitioner.

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

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

1. Patient/ Member details

Full name*

First name(s)

Last name

Policy/ Membership number

Date of birth* (dd/mm/yy)

Address*

Email

Phone number

2. Patient Declaration

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

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 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 medical 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.

Patient's full name

Patient's (or guardian's) signature

Please select one:

I request that my practitioner send this form directly to UniMed at claims@unimed.co.nz.

OR

I request that my practitioner send this form back to me. I will send it to UniMed at claims@unimed.co.nz.

Date signed (dd/mm/yy)

3. Critical diagnosis claim details

Please select one or more of the options below that are relevant to your claim:

Cancer

Loss of function and/or independent living

Cardiovascular

Other conditions (as stated in the Health Plan document)

Organ failure

4. Details of the medical practitioner the Member has consulted

Medical practitioner's name

Medical specialty

Physical address

Phone number

Email

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE MEDICAL PRACTITIONER.

5. Clinical details

NOTE TO THE PATIENT'S MEDICAL PRACTITIONER

The 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.

UniMed is not liable for any costs associated with the completion of this form. If the space allowed for answering any of the questions is insufficient, please attach a separate sheet. Please complete the following questions to help us thoroughly evaluate your patient's claim. Provide as much detail as possible.

What is the health condition that has resulted in this claim?

On what date was the patient first aware of signs and/or symptoms relating to their health condition?

On what date did the patient first seek medical advice relating to their health condition?

On what date was the patient first informed of their diagnosis?

Has the patient had any previous medical history relevant to the health condition associated with this claim?

Yes No

If yes, please provide the details.

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6. Supporting documentation

Please provide copies of all relevant supporting documentation:

General

- A copy of the medical reports relating to the health condition.
- A copy of all relevant pathology reports.
- Operation notes or other details regarding treatment provided or recommended.

Loss of independent living

- A copy of the results relating to the functional assessment.

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7. Declaration by medical practitioner

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 and with 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 and am not the patient, the Primary Member or either of their respective partners or relatives.

Medical practitioner'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.