CLAIM FOR MEDICAL EXPENSES

REIMBURSEMENT TO MEMBER

POSTAL ADDRESS
PO Box 1721, Christchurch 8140
Phone: 0800 600 666

HEAD OFFICE
165 Gloucester Street, Christchurch 8011

www.unimed.co.nz
claims@unimed.co.nz

PATIENT'S NAME	MEMBERSHIP NO.
FULL ADDRESS	
EMAIL ADDRESS	

I certify that the surgery, treatment or procedure was performed and all particulars shown on this claim are true and correct. I authorise UniMed to obtain any further medical information they may need in connection with this claim submitted by me or my listed dependants. UniMed may disclose information related to this claim to the Integrity Register for the purposes of the detection of fraudulent and suspicious conduct.

Signed _____ Date_____

I would like any refund credited to my bank account: (Please complete)	Use this bank account No. for: *(Please tick)*
☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐	✔ ☐ For this claim only ☐ For all future claims

MEDICAL EXPENSES WHICH I AM SEEKING REIMBURSEMENT

Please list accounts for all expenses individually. **The actual conditions/symptoms treated must be shown.** "GP visit", "X-ray" and the like are **not** sufficient.

PATIENT	DATE OF BIRTH	PROVIDER/SERVICE	REASON FOR VISIT OR SERVICE	DATE OF VISIT	AMOUNT PAID
Sally	*01/01/1940*	*e.g. GP Visit*	*e.g. sore throat, flu*	*01/12/2020*	*$25.00*
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Attach
Original Receipts and Invoices Here

PRESCRIPTIONS

Pharmacist receipts must show the name of the patient, prescription number, the name and cost of each medication prescribed.
Each prescription charge is to be listed individually.

PATIENT	DATE OF BIRTH	MEDICATION	DATE OF VISIT	AMOUNT PAID
Sally	*01/01/1940*	*e.g. Augmentin*	*01/12/2020*	*$25.00*
	/ /			*$*
	/ /			*$*
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	/ /			*$*
	/ /			*$*
	/ /			*$*
			TOTAL CLAIM	***$***

ACCEPTANCE CHECKLIST

☑	*(Please tick)*
☐	All claims are supported by the original itemised accounts and receipts showing the name of the patient, date of consultation, description of service, qualification and GST number of the provider. (EFTPOS and credit card receipts are **not** acceptable without the original itemised accounts).
☐	Receipts exceed $50 in total, unless no claim made in a year, and are less than 15 months old from the date of incurring the cost.
☐	An itemised account, if claiming for multiple visits, attached.
☐	Accounts and receipts are attached in the same order as listed on the claims form.
☐	The declaration is signed.
☐	My address has changed since the last claim.

PUBLIC HOSPITAL ADMISSION

☑	*(Please tick)*	The 'Public Hospital Cash Grant' payment will only be made on receipt of the Hospital Discharge notice.
☐	Attached	

The Privacy Act 2020 requires UniMed to inform you about certain rights and obligations relating to the information which we collect on this form. In this regard we recommend that you read the Privacy Statement on our webpage www.unimed.co.nz. The Integrity Register is a register of health insurance claims and administered by PwC (on behalf of the Financial Services Council) for the purposes of the prevention and detection of fraudulent and suspicious conduct. The collection of information complies with the Privacy Act 2020 and the Health Information Privacy Code 2020.