Manchester Unity Friendly Society
EST. 1842
Members helping Members

MEDICAL INSURANCE - CLAIM FORM

I am claiming as (Tick box): ☐ a Member or ☐ a Dependent

Claimant's details:

*If you are claiming as a Dependent of a Member, please also complete the "Claimant's Member's Details" section below

Membership Number: ☐☐☐☐ ☐☐☐☐☐

Full Name: ______________________

Address: ______________________

Contact Phone Number: Home: ____________ Work: ____________ Mobile: ____________

Email Address: ______________________

Date of Birth: ____/____/____

Claimant's Member's Details (**Only complete if you are claiming as a Dependent)*

Full Name: ______________________

Address: ______________________

Contact Phone Number: Home: ____________ Work: ____________ Mobile: ____________

Email Address: ______________________

Date of Birth: ____/____/____

Bank account details, for the Rebate/direct credit:

Name of the Account holder: ______________________ Bank: ____________

Account number: ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐

Declaration:

Are you entitled to any payment in respect of this claim from any other source?

☐ **Yes** ☐ **No**

If yes, please include a schedule with this claim

I certify that:

- All information provided with this claim is true, correct, fully disclosed and complete
- For claimants under 16 years of age, the information and declaration has been completed by the parent(s) or legal guardian
- I consent and give authority to Manchester Unity to obtain any further personal or health information they many require with regard to this claim

____

Your signature **Date:** ____/____/____

Office use only:

Plan type: Basic Plan/ Premier Plan/ Wellness Plan

Optional extra: Dental/ Optical/ Wellness/ Hospital stay

Hospital stay - Category: ☐

IMPORTANT - PLEASE READ CAREFULLY TO AVOID ANY DELAY IN RECEIVING YOUR REBATE.

- Pre-approval is required should your claim be over $1,000
- Please ensure you quote your Membership number. All claims are payable to the Member, or direct to the pre-approved Hospital or Registered Medical Practitioner.
- To be valid, claims must be submitted within 12months of incurring the charge on an Eligible Medical Service. Where your Policy ends in accordance with clause 5 of the Policy Wording, Manchester Unity must receive your claim within 1 month of the Policy End Date.
- Claims are normally settled within 7 working days. Claims will be paid into your designated bank account unless, for surgical expenses, you have obtained Pre-approval and require your costs to be direct credited to your to your Registered Medical Practitioner.
- To be valid, the declaration must be signed by You, conform to the following procedure and by signing the declaration, you agree to the conditions of the procedure.

Claims Procedure

1. Only original receipts are to be submitted with your claim. These must show the name of the patient, date of visit(s), treatment and costs involved. Eftpos, credit card receipts or photocopies of accounts will not be accepted for processing.
2. If your receipt is for more than one consultation, please list the date and the amount charged for each visit as you are entitled to a Rebate payment for each visit.
3. Nature of Illness or treatment received must be completed by advising actual condition or symptom. “Consultation” is insufficient and your claim will be declined.
4. Prescription drugs must be listed on the PHARMAC Schedule, and you must be eligible to meet PHARMAC funding criteria, that is a current “Special Authority”. The receipt must be endorsed as such by the dispensing pharmacy.
5. Pharmacy claims are only payable on a Registered Medical Practitioner’s prescription. The receipt must show the date, name of person treated, the prescription number and medication prescribed.
6. Calculation of Rebate shall be AFTER deduction of any recoveries under UFS, Work & Income New Zealand (WINZ), or expenses recoverable from a third party or under any contract of indemnity or insurance. No Rebate shall be payable in respect of any excess, service charge, surcharge or like charge which the Government, Medical Authority or Accident Compensation Act 2001 may apply to medical-related services.
7. If you have received another insurers’ refund for Eligible Medical Service(s), Manchester Unity will Rebate the balance up to the limits of your Policy. You must disclose the other insurers’ refunds by submitting a copy of their remittance advice. You shall not receive a Rebate which together with any other refunds, subsidies, or entitlements amounts to more than 100% of the actual costs incurred for any Eligible Medical Service.
8. Original receipts will be returned only if a written request accompanies the claim form. In addition, receipts will be stamped indicating the level of the Manchester Unity refund.

Send your completed claim form to, and direct all inquiries and assistance to:

Manchester Unity Friendly Society,
Freepost 2016, PO Box 5083, WELLINGTON 6140

Email: medical@manchesterunity.org.nz
Phone: 0800 101 842, Fax: (04) 471 2256

HOSPITAL STAY CLAIMS ONLY - ATTACH HOSPITAL DISCHARGE SUMMARY

(The hospital discharge summary MUST be attached as proof of your hospital stay. Failure to provide the discharge summary may delay your Rebate.)

Please complete the sections below. ALL information must be provided.

Name of Patient	Name of Hospital	Public/Private (please indicate which)	Date of Admission	Date of Discharge	Name of Doctor or Surgeon

Medical Condition Treated: ______________________________

Procedure/Treatment provided: ______________________________

SURGICAL CLAIMS ONLY - ATTACH THE ITEMISED ACCOUNTS AND COMPLETE THIS SECTION

Pre-Approval Number: ____________________

Patient's Name: ____________________

Procedure	Name of provider/facility	Date of Procedure	Pay provider		Amount charged
			YES	NO	
		/ /			$
		/ /			$
		/ /			$
		/ /			$
		/ /			$
		/ /			$
		/ /			$
		/ /			$
		/ /			$
		/ /			$
				TOTAL TO PROVIDER(S)	$
				TOTAL TO CLAIMANT	$

Office Use Only

Pre-Approved by: ____________________

NON-HOSPITAL AND NON-SURGICAL CLAIMS ONLY - ATTACH ORIGINAL RECEIPTS

Date	**Name of Claimant**	**Name of provider**	Office use only	**Full details of nature of illness or treatment received**	**Fee charged**	Office use only