Manchester Unity Friendly Society
EST. 1842
Members helping Members

MEDICAL INSURANCE - REQUEST FOR PRE-APPROVAL

I am requesting for a pre-approval as (Tick box): ☐ a Member or ☐ a Dependent

Requester's details

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

Membership Number: ☐☐☐☐ ☐☐☐☐☐

Full Name: _____

Address: _____

Contact Phone Number: Home: _____ Work: _____ Mobile: _____

Email Address: _____

Date of Birth: ____/____/____

Requestor's Member's Details (*Only complete if you are requesting as a Dependent)*

Full Name: _____

Address: _____

Contact Phone Number: Home: _____ Work: _____ Mobile: _____

Email Address: _____

Date of Birth: ____/____/____

Pre-Approval Details

Details of condition (including any previous treatment to condition):

_____

_____

_____

Date of first symptoms: _____ Is this pre-approval ACC related: _____

Procedure/treatment performed: _____

_____

_____

Name of Hospital: _____

Admission date: ____/____/____ Number of nights stay: _____

Declaration:

I certify that

- All information provided with this claim is true, correct, fully disclosed and complete
- For requesters under 16 years of age, the information and declaration have 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 may require with regard to this pre-approval

_____

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

Estimated costs:

Please attach all quotes obtained OR ensure this page is completed and signed by your Registered Medical Practitioner

	Name of the provider	Cost $	Office use only	
			Code	Cost $
Surgeon				
Anesthetist				
Accommodation				
Theatre				
Recovery				
Prosthesis				
Surgical equipment				
Sundries				
X-rays/ Scans/Ultrasounds				
Consultations				
Physiotherapy				
ECG				
Other				
TOTAL				

_____

Signature of Registered Medical Practitioner

Date: ___/_____/_____

PLEASE ATTACH AND RETURN WITH THIS PRE-APPROVAL APPLICATION:

- The written estimate(s) from your provider(s) including surgeon's fee, pre and post operative consultations, anaesthetist fee, hospital costs, and any other test costs
- A copy of the referral letter from your general practitioner, OR a copy of the report from your specialist to your general practitioner following your consultation.

Send your completed request for Pre-Approval form 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

Office use only:

Pre-approval number:

Approved by: