POSTAL ADDRESS
PO BOX 1721
CHRISTCHURCH
PH 365-4048

UniMed
YOUR HEALTH INSURER

HEAD OFFICE
163 GLOUCESTER ST
CHRISTCHURCH

CLAIMS FORM

Acceptance Checklist

	✔
Are all accounts paid, and the original accounts WITH receipts attached to the claims form?	☐
Receipts must exceed $50 for your claim to be accepted (unless you have not claimed in the preceding year)?	☐
Are all receipts less than 15 months old? (They must be for the Society to refund them.)	☐
If claiming for multiple visits on one receipt have you attached an itemised account from your doctor?	☐
Is the claims form fully completed (both sides) including a precise description of the nature of illness for each visit? NB "consultation" or "check up" is NOT sufficient.	☐
Has the Hospital admission section (if applicable) been completed by the attending physician or surgeon?	☐
HAS YOUR ADDRESS CHANGED SINCE YOUR LAST CLAIM?	☐
Have you signed the declaration below?	☐

Member's Name ..... Membership No. .....

Full Address .....

..... Employer .....

I certify that all particulars shown on this form are true and correct and I hereby authorise UniMed to obtain any further medical information they may need in connection with any claim submitted by me or my listed dependants.

Signed ..... Date .....

PUBLIC/PRIVATE HOSPITAL ADMISSION (Cross out one).

This panel must be completed ***by the attending Physician or Surgeon*** or, in the case of a Public Hospital, by the Medical Records Office.

Patient's Name ..... Date of Birth .....

Nature of illness? .....

Procedure performed? .....

Was this condition due to personal injury by accident or an employment related condition? Yes/No
(please cross out one)

Date admitted ..... Date discharged .....

Stamp here

Signed .....

Name .....
(Attending Surgeon or Physician)

PLEASE TURN OVER FOR GENERAL MEDICAL EXPENSES CLAIMS.

Attach Receipts Here

IMPORTANT - PLEASE READ CAREFULLY

Please list receipts for all medical costs and ALL PRESCRIPTION CHARGES INDIVIDUALLY, below. "Consultation" or "check up" is NOT sufficient for the "Reason for Visit" section (this information is for audit and planning purposes and helps ensure that benefits are kept current).

All claims cheques are payable to the member.

	Reason for visit (**must** be advised) LIST MEDICAL COSTS HERE	Patient	Date of birth	Date of visit	Amount paid	Office use
eg	TONSILLITIS	SALLY	01/ 01 /40	01/ 03 /92	$ 25-00	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
	LIST PRESCRIPTIONS HERE (for "Reason for Visit" put medication name from chemist's receipt)					
eg	AUGMENTIN	SALLY	01/ 01 /40	01/ 03 /92	$ 12-00	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	
			/ /	/ /	$	

TOTAL CLAIM $ _____

PLEASE NOTE: It will greatly assist our claims staff if your receipts are attached to the claims form in the **same order as they are listed above.** This will enable your claim to be processed with the minimum delay.

HAVE YOU COMPLETED THE FRONT OF THIS FORM?