Southern Cross Health Society

Prior approval application

To help us process your application as quickly as possible, please answer the relevant sections below.

Please note, some fields are marked with an *. We cannot process your prior approval application without this information.

The fields not marked with an * are optional. They will provide us with additional information that may be useful/necessary depending on the procedure that you are seeking prior approval for. If you have this information, please provide it as this may speed up your prior approval application.

Here's some of the information you will need to fill in this form.

1. Name and details of the policyholder (address, contact numbers, etc).
2. Membership number of the policyholder.
3. Name and date of birth of the patient.
4. Name of the treatment, hospital/facility name, surgeon's name and their addresses.
5. A breakdown of the costs. This can be provided by your healthcare service provider.
6. Your correct contact details, as this will be used in responding to your prior approval request.

We aim to inform you of the outcome of your application within 3-5 working days of receiving this form, unless further information is required.

- If prior approval is issued, a letter will be sent to the policyholder.
- Any prior approval issued is subject to policy terms and the conditions set out in the prior approval letter.

Please note, in some circumstances (for example, if the procedure is imminent or we require further clarification) we may need to contact you by phone to ensure that your inquiry/application is progressed efficiently.

1. POLICYHOLDER DETAILS

Policyholder's name _____ Membership number* | | | | | | | | |

Date of birth* _____/_____/_____

Mailing address as on policy* _____
Street number Street Suburb Town/city

Home phone* | | | | | | | | | | Mobile phone | | | | | | | | | | |

Business phone | | | | | | | | | | Fax | | | | | | | | |

E-mail _____

2. PATIENT AND PROCEDURE DETAILS

Name of patient* _____ Date of birth*_____/_____/_____

Full name of your usual doctor (GP)*_____

Intended procedure*_____
(Specify body part including left or right)

Intended procedure date _____/_____/_____ Intended hospital*_____

Hospital address _____
Street number Street Suburb Town/city

Intended surgeon/referring doctor for scans* _____
(If surgery, name of surgeon. If diagnostic scan, name of referring doctor)

Surgeon's address _____
Street number Street Suburb Town/city

Surgeon's phone | | | | | | | | | | Surgeon's fax | | | | | | | | | |

3. PROCEDURE COSTS QUOTED BY YOUR HEALTHCARE SERVICE PROVIDER

Provider/service cost		Provider/service cost	
Surgeon	$_____	Hospital accommodation	$_____
Anaesthetist	$_____	Theatre time (in minutes)	_____
Radiology/diagnostics	$_____	Theatre fee	$_____
Prosthesis	$_____	Other (CT/MRI scan; Cardiac Test; Interventional Radiology)	$_____
		Total procedure cost	$_____

4. DETAILS OF THE CONDITION

What was the underlying condition that made the surgery/treatment necessary?*

_____

_____

When did the signs and/or symptoms of the condition become apparent for the very first time?*

_____

_____

When did you first seek medical advice?*

_____

_____

Other comments_____

_____

_____

Is this claim accident/injury related? ☐ Yes ☐ No

If Yes, in what country did the accident/injury occur?_____

Date of injury _____/_____/_____

PRIVACY ACT REQUIREMENTS

This information is being collected by Southern Cross Medical Care Society for administration purposes, including considering whether a particular healthcare service is eligible for cover under your policy.

You have the right of access to, and to request correction of, any personal information held by Southern Cross.

A copy of the full Southern Cross privacy statement is set out in your policy document.

I am authorised to complete and submit this application on behalf of the person named in it. I declare that the information I have disclosed is true and complete and is disclosed in accordance with the terms of the Southern Cross Privacy Statement.

PLEASE NOTE THAT THIS FORM IS NOT AN ACCEPTANCE OF YOUR APPLICATION

POLICYHOLDER SIGNATURE

Signed _____ **Date** _____/_____/_____

Please return this authority to Southern Cross Medical Care Society by either

- faxing to 09 375 0008, or
- posting to Southern Cross Medical Care Society, Private Bag 99934, Newmarket, Auckland 1149.

For more information phone Member Services on 0800 800 181 or visit www.southerncross.co.nz/priorapproval