PRIOR APPROVAL FORM

FOR DIRECT PAYMENT OF SURGICAL COSTS

PRIOR APPROVAL FORM

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	DATE OF BIRTH
EMAIL ADDRESS	PATIENT'S PHONE NUMBER

1. I hereby apply to UniMed for confirmation that my proposed surgery is covered under my chosen plan and to reimburse all Healthcare Service Providers directly.
2. I certify that all particulars shown in this form are true and correct and authorise UniMed to obtain any further information they may require in relation to this claim submitted by me or my listed dependants.
3. I have a duty to disclose ALL information relevant to this claim and to provide additional reports before the date of my surgery/procedure or treatment, should new information arise from the time I sought prior approval.
4. UniMed may disclose information related to this claim to the Integrity Register for the purposes of the detection and prevention of fraudulent and suspicious conduct.
5. I acknowledge that until UniMed issues the claims approval documentation any costs incurred are my own responsibility.

Signed _____ Date_____

MEDICAL REPORT TO BE COMPLETED BY YOUR USUAL FAMILY DOCTOR (GP)

1. How long have you been the patient's attending physician?

2. Nature of the illness that makes the proposed surgery necessary

3. How long has this condition or associated symptoms been present

Please provide a brief extract of the medical records related to this condition and associated symptoms which includes a brief description of the treatment received.

_____

_____

_____

_____

_____

_____

_____

4. Please provide the following reports: ☐ Referral letter(s) ☐ Specialist Reports ☐ Diagnostic Investigations Reports

5. Is this condition related to a personal injury as defined under the Accident and Compensation Act 2001? ☐ Yes ☐ No

6. If "Yes" – date of injury or onset of condition?

7. Has an application been made to ACC? ☐ Yes ☐ No

8. Was this successful? (Please enclose copies of all correspondence between ACC, the patient and medical provider e.g. decline letter, ARTP report. ☐ Yes ☐ No

ATTENDING PHYSICIAN NAME DATE PRACTICE STAMP HERE

ESTIMATED SURGICAL COSTS

PLEASE OBTAIN THE FOLLOWING INFORMATION FROM YOUR SURGEON AND HOSPITAL

PROPOSED SURGERY/PROCEDURE
MEDICAL CONDITION TREATED
DATE OF SURGERY
NAME OF SURGEON
NAME OF ANAESTHETIST
NAME OF HOSPITAL

PRIVACY STATEMENT

Pursuant to the Privacy Act 1993 and the Health Information Privacy Code 1994 –

1. The information provided in this prior approval form collects information for the purpose of assessing the Member's cover for this procedure.
2. This information will be held at the Union Medical Benefits Society Limited Head Office at 165 Gloucester Street, Christchurch.
3. You have the right to access and to request correction of this information, subject to the provision of the Privacy Act 1993.
4. The integrity Register is a register of health insurance claims and administered by PwC (on behalf of the HFANZ) for the purposes of the prevention and detection of fraudulent and suspicious conduct. The collection of the information for this register complies with the privacy Act 1993 and the Health Information Privacy Code 1994.

I declare that the above information provided by me is true and correct.

SIGNATURE OF SURGEON DATE PRACTICE STAMP HERE

ESTIMATED COSTS FOR THE PROCEDURE

PLEASE NOTE: It is important for UniMed to know the anticipated liability with regard to the payment of our client's surgery. Please provide the costs as comprehensively as possible.

Surgeon's fee	$
Anaesthetist fee	$
Hospital fee per day	$
Theatre fee	$
Hospital supplies	$
Prosthesis costs	$
Laparoscopic disposables	$
Other eg. physio, xrays, nursing fee	$
Total estimated cost	**$**

Number of days	
Theatre time	
Type of prosthesis	