



Form - PH 01

HEALTHCARE 99 REQUEST FOR PRE-APPROVAL OF TREATMENT COSTS



PLEASE COMPLETE ALL SECTIONS AND RETURN TO:
Healthcare 99, PO Box 74301, Green Lane, Auckland 1546

Name of Member _____ Date of Birth _____

Patient Name _____ Healthcare 99 _____

Address _____ Membership Number _____

City _____ Postcode _____ Phone Contact Number _____

Email _____

Healthcare 99 is a mutual fund not an insurance scheme

Is this covered by ACC/AES? YES/NO

PLEASE SUPPLY A LETTER OF REFERRAL FROM GP/SPECIALIST

HOSPITALISATION

Name of Hospital _____ Date of Treatment _____

Estimated Total Cost \$ _____

Hospital Room Costs \$ _____

Theatre \$ _____

Prosthesis/implants \$ _____

Sundry Expenses \$ _____

Surgeon Operation \$ _____

Pre/Post Surgery Consultations \$ _____

Anaesthetist Operation \$ _____

Pre/Post Surgery Consultations \$ _____

DIAGNOSIS AND TREATMENT

Diagnosis _____

Proposed Treatment _____

Southern Cross schedule code number _____

SURGEON DETAILS

Name _____ Phone _____

Address _____

OFFICE USE ONLY

Has claim been approved? YES NO Date _____



Signature _____

Privacy Statement

This document collects personal information about you so the New Zealand Firefighters Society can consider your claim.

The information is received and held by the New Zealand Firefighters Welfare Society, Private Bag 31999, Lower Hutt 5040.

You may request access to, and correction of, this information according to the provisions of the Privacy Act 1993.

I declare to the best of my knowledge the details given in this claim form are true.

I agree that the New Zealand Fire Fighters Welfare Society may give or obtain from appropriate individuals or organisations information relevant to evaluate and administer this claim.

With regard to any injury or illness, I hereby authorise any hospital, physician or other person who has attended me to furnish the New Zealand Firefighters Welfare Society, or its representatives, with any and all information with respect to any medical history, consultation, prescription or treatment and copies of all hospital or medical records.

I agree that an electronic version of this authorisation shall be considered as effective and valid as the original and that electronic invoices submitted are copies of the original invoices (please retain the original invoices in case we require them later).