Claim and Pre-approval

You can lodge your claim online, or using the nib app. It's easier, and faster!

1.0 About your policy

Please answer the applicable sections fully before you date and sign this form. If you need assistance in completing this form please visit **nib.co.nz**

Contact details

Full name

Home phone ( )

Mobile ( )

Email Address

All correspondence will be sent to the email address of the policyowner(s). A valid email address must be provided.

1.1 Please tick one of the boxes below, indicating what type of health claim you are making

- ○ **Pre-approval request** for surgery, private hospitalisation, chemotherapy, radiation therapy, diagnostic investigation (including CT and MRI) and / or specialist consultation. **(Please complete sections 1.0, 2.0, 3.0, 3.1 and 6.0) (PAF)**
- ○ **Payment request for a claim that has been pre-approved.** Please attach the Pre-approval letter to the invoices and submit or supply pre-approval number here: and complete **sections 1.0, 4.0 and 6.0 (HCFD)**
- ○ **Payment request for a claim that has NOT been pre-approved** for surgery, private hospitalisation, chemotherapy, radiation therapy, diagnostic investigation (including CT and MRI), and / or specialist consultation. **(Please complete sections 1.0, 2.0, 3.1, 4.0 and 6.0) (HCFUS)**
- ○ **Payment request** for GP, dental, optical or other **medical expenses**. (**Please complete sections 1.0, 4.0 and 6.0**) (**OHCF**)
- ○ **Payment request** for a specialist consultation (not related to surgery). (**Please complete sections 1.0, 3.1, 4.0 and 6.0**) (**OHCF**)

Note: For pre-approvals, please ensure your GP referral and specialist letter are attached. Please note there will be a delay in processing your claim if all relevant sections are not completed.

2.0 About your claim (to be completed by the patient)

Name of patient (insured person)		Date of birth	d d m m y y y y
Proposed treatment / operation / diagnostic investigation		Proposed date	d d m m y y y y

Proposed length of hospital stay (number of days)	d d d	Day stay?	○ Yes ○ No
Do you have any other insurance policy you could claim against? If "Yes", please give details, including policy number.			○ Yes ○ No

Note: You must attach a copy of your specialist consultation letter and the quotation for the treatment / operation / diagnostic investigation.

3.0 About the pre-approval cost

Note: Please attach quotes obtained.

Treatment / operation / diagnostic investigation costs as quoted by your specialist

Provider / service	Cost	Name of Hospital and specialist
Specialist	$	
Anaesthetist	$	
Radiology (i.e. MRI scan, CT scan)	$	
Prosthesis	$	
Hospital costs	$	
Other	$	
Total procedure cost	$	

3.1 Medical report (to be completed only by your usual family doctor, GP, dentist or optometrist)

Please attach a copy of the Referral Letter to the specialist
Please also attach any supporting documentation stating when symptoms or signs of this health condition first became apparent to you.

Current doctor's details	Previous doctor's details (if known)
Doctor's name	Doctor's name
Phone ( )	Phone ( )
How long have you attended him / her?	How long have you attended him / her?
Doctor's address	**Doctor's address**
Street name and number	Street name and number
Suburb	Suburb
Town / City	Town / City
Postcode	Postcode

Patient details

Patients Surname		Given Name(s)	

What is the underlying health condition that made the surgery / treatment / diagnostic necessary?

What was the date the patient first noted the symptoms?

What was the date the patient first sought investigation or medical advice?

Please provide details of any subsequent consultations / investigation / treatment / surgery including dates:
(Please also provide copy of GP referral letter and first consultation letter).

If the patient has required surgery / treatment / investigations for this or a similar condition before, please provide details including dates:

Is this condition ACC related? (Please attach the ACC Acceptance / Decline Letter)	Yes No
Please attach a histology report, if applicable, regarding the above health condition.	Attached

Authorised Signature

Family doctor / GP, dentist or optometrist

Full name	Date	Signature
	d d m m y y y y	

3.2 About your representative (if applicable – to be completed by the insured person)

I give my authority for any details of this claim to be provided to:

My adviser	Yes No
Adviser's name	

Or:

Contact details

Name and relationship to patient

Home phone ( )

Mobile ( )

Email

4.0 Refund for all types of claims (to be completed by the insured person)

Important notes:

- Claims must be supported by the original itemised accounts and receipts (not copies) showing the name of the patient, date of consultation, description of services; as well as the name, qualification and GST number of the provider of the service. Pharmacist receipts must show the name of the patient, prescription number and name of the medication prescribed and the cost of each item.
- Please ensure that all accounts and receipts are submitted to nib nz limited, within 12 months of incurring the cost. Claims must be submitted within 30 days after the termination of the policy.
- If you require more space to provide the details below, please complete the details on a separate sheet, attach it to this claim form and ensure you include your policy number on the separate sheet.

First name of insured person	Date of treatment	Name of provider	Reason for service / item provided	Amount	If refund is to you directly, please indicate below
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
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				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
			Total Claim	$	

5.0 About your refund (to be completed by the policyowner(s)

We pay claim refunds by direct credit into your nominated bank account. Please attach a deposit slip or fill in details below. Please print clearly. If a claim is accepted, refunds can not be paid when a policy premium is in arrears unless the policyowner(s) have provided authority to deduct any outstanding premiums from any claims payment.

5.1 Bank account details

Name on account

Account number

Name of bank

Name of branch

6.0 Important information and declaration (to be completed by the policyowner(s) and the patient)

Privacy Act 2020 and Health Information Privacy Code 2020
Collection and use
This form collects personal and health information. nib will use the information it collects to:

- consider claims and provide the benefits and health related services under the policies, and
- administer the policies, and
- promote and/or market our current and future health and related services and health related products of nib's business partners.

You and anyone else named in this claim form must tell us everything you know (or ought to know) which would influence the decision of a prudent insurer whether to accept this claim. If any applicant or insured person fails to provide information required by the duty of disclosure, nib may decline the claim or pre-approval request. When in doubt, disclose.

Intended recipients
In providing our health and related services and using personal information, we may collect information from or disclose personal information to:

- nib and its related companies and business partners, and
- all other policyholders and insured persons, and
- the insurance adviser or other individual who a person has granted authority to access information on their behalf, and
- at claim time:
  - all necessary health service providers
  - any of nib's contractors or service providers assisting it with administering and meeting each applicant's and insured person's claim

You and each person named in this claim form authorise the collection of information from and the disclosure of information to the intended recipients named for the purposes set out above.

Access and correction
The accuracy of personal information is important to us. We will take reasonable steps to ensure a person's information is accurate, complete and up-to-date. We rely on the policyholder(s) and/or insured person to advise of any changes to their contact details and any other personal information. Each person has the right to access and correct their personal and health information held by nib. nib nz limited, 48 Shortland Street, Auckland collects and holds the personal and health information.

Signature

Before signing please ensure that you have answered all the questions and have read and understood the 'Important information and declaration' above.
Note: To be signed on behalf of a patient under age 16 by the patient's parent / legal guardian.

Full name	Date	Signature
Patient name	d d m m y y y y	
Policyowner (if different)	d d m m y y y y	

6.1 Important reminders

- Please ensure you have completed all the relevant sections, and signed and dated **section 6.0**
- Please note that completion and submission of this form is not an acceptance of your claim
- For payment requests, please supply original invoices.