Avoid delays processing your claim - please follow the instructions for submitting claims electronically on the Health Plan Claim Form web page

POLICE HEALTH PLAN
CLAIM FORM

Claim No. *(Office use only)*

Phone (04) 496 6800, Freephone 0800 500 122
Fax (04) 496 6819, PO Box 12344, Wellington 6144
Email health.claims@policeassn.org.nz, Web www.policeassn.org.nz

Complete this form for any medical expenses you have paid for yourself.

DETAILS OF POLICYHOLDER

Member no.

First names | Last name

Postal address

Postcode

Preferred email address *(For all correspondence)* | Home phone | Mobile

REFUND DETAILS

Please send my refund summary (*please tick one*) ◯ By email ◯ By post

I would like any refund credited to the following account. *Please select one. If neither option is selected, your Credit Union account will be credited.*

◯ Credit Union account ◯ Other bank account *(Complete details)*

Please refund the following medical expenses

Patient's first name	Treatment date	Provider/Service: e.g. GP, Specialist	Work-related injuries Y / N *(Police only)*	Reason for visit e.g. sore throat, flu	Amount paid	*Office use only*
				Total	$ 0.00	

If you require more space, please complete the remaining details on page 3.

PUBLIC HOSPITAL CASH BENEFIT – INCLUDES MATERNITY & NON-SURGICAL ADMISSIONS

Please provide confirmation of your reason(s) for admission from a medical professional i.e. letterhead letter, discharge papers etc.

Patient's first name | Last name

Hospital | Admission date / / | Discharge date / / | Nights in hospital

Reason for admission

PLEASE COMPLETE DECLARATION ON NEXT PAGE

DECLARATION

This document collects personal information about you so Police Health Plan Ltd can consider your claim. The information is received and held by Police Health Plan Ltd, PO Box 12344, Wellington 6144. You may request access to, and correction of, this information according to the provisions of the Privacy Act 1993.

Police Health Plan Ltd is a member of Health Funds Association of New Zealand (HFANZ). On behalf of its members, HFANZ manages an Integrity Registry for the purposes of detecting and preventing fraud and other serious probity concerns. The Integrity Registry is operated by PricewaterhouseCoopers. In submitting this form you are authorising Police Health Plan Ltd to collect, use and disclose personal and health information about you for the purposes of the Integrity Registry. You can access and correct information held on the Integrity Registry. Contact Police Health Plan Ltd or HFANZ Integrity Registry Privacy Office , Health Funds Association of New Zealand, PO Box 25161, Wellington 6146.

- I declare to the best of my knowledge the details given in this claim form are true.
- I agree that Police Health Plan Ltd 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 Police Health Plan Ltd, 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).

Policyholder Name _____ **Signature** _____ **Date** / /

If completing electronically, put an "X" in this box to confirm consent to the above declaration.

CLAIM FORM CHECKLIST

- ◯ Medical expenses being claimed are within 18 months of the date of treatment.
- ◯ All accounts/receipts for this claim are the originals or, if being submitted electronically, are attached as a PDF or JPG and are easily readable (or processing of your claim may be delayed). Refer to www.policeassn.org.nz for full guidelines.
- ◯ All invoices/receipts for this claim include:
  a. Name of the patient and date of each treatment
  b. Name & qualifications of the practitioner who provided the treatment
  c. Prescription receipts show the name of the drug and prescription number
  d. Eftpos receipt print-offs are not suitable for claim purposes
- ◯ All items being claimed have been fully completed in the Refund Details section of the claim form, especially the reason for treatment. Failure to do so may affect the processing of your claim.
- ◯ Submitting claim electronically - the instructions on the Health Plan Medical Claim Form web page have been followed. Invoices and claim form are attached as PDF or JPG to the email (not embedded in email).

Once completed, send to Police Health Plan: health.claims@policeassn.org.nz *Remember to send claim form and invoices as PDF or JPG attachments.* | Police Health Plan, PO Box 12344, Wellington 6144

WHAT HAPPENS NEXT

- We aim to have all claims processed within 10 working days (usually shorter).
- Claim payments are made every Wednesday and should appear in your nominated account the next day. Details of your claim payment will be sent to you.
- You can check the progress of your current claim under 'My Profile when logged into www.policeassn.org.nz.

ADDITIONAL INFORMATION

- All medical expenses relating to injury need to be first referred to ACC.
- No refunds will be paid when subscriptions are in arrears.
- For circumstances requiring surgery, please complete a Surgical Approval form – visit 'Forms and Documents' at www.policeassn.org.nz.
- Police Health Plan policy cover details, forms, FAQs and claim processes are available on the website, visit www.policeassn.org.nz.
- Work-related treatment costs: Current serving members of Police must approach their Police District Human Resources Office for reimbursement of treatment costs associated with an injury sustained at work, and for ACC purposes, accepted as a work accident. In the event such costs will not be met by NZ Police, members can submit a claim to Police Health Plan along with confirmation from NZ Police that they will not meet these costs

CONTACT US

(04) 496 6800 or 0800 500 122
(04) 496 6819
PO Box 12344, Wellington 6144
health.claims@policeassn.org.nz
www.policeassn.org.nz
NZPoliceAssociation
@NZPoliceAssn

43149-12-18

Medical expenses continued from first page

Please refund the following medical expenses

Patient's first name	Treatment date	Provider/Service: e.g. GP, Specialist	Work-related injuries Y / N *(Police only)*	Reason for visit e.g. sore throat, fl	Amount paid	*Office use only*
				Total		