PLEASE READ

Before completing the attached PH I form, please refer to the instructions below.

To ensure we are able to consider your request in full, you ***must*** complete the form and return it along with the estimated costs from your treatment provider. You ***must*** also provide a copy of the referral letter from your Specialist, which will inform us of:

- the diagnosis;
- proposed operation or treatment;
- the reason it has been requested.

Our intention is to process all requests in a timely manner; however, failure to supply all relevant documentation could result in delays. Should all be in order, we will endeavour to have a decision within 10 business days and communicate this back to you in writing.

Please note that under no circumstances will any payment for in-hospital operations or treatment be made without prior approval having been confirmed. Further, any payments will only be made to the Member and not directly to the treatment provider.

Should you have any queries on the pre-approval process, please feel free to contact Mark Langford, Claims Broker, Aon New Zealand on 0800 50 51 52 or email nz.healthcare99@aon.com

Form - PH 01

HEALTHCARE 99 REQUEST FOR PRE-APPROVAL OF TREATMENT COSTS

PLEASE COMPLETE ALL SECTIONS AND RETURN TO:
AON, PO BOX 2845, WELLINGTON 6140 - Ph 0800 50 51 52

Name of Member _____ Date of Birth _____

Patient Name _____

Address _____ Healthcare 99 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 _____

Southen Cross schedule code number _____

SURGEON DETAILS

Name _____ Phone _____

Address _____

OFFICE USE ONLY

Has claim been approved? YES NO Date _____

_____

Signature

07/08/17