Reimbursement of Health Overcharges Application

Work and Income
Te Hiranga Tangata

A service of the Ministry of Social Development

CLIENT NUMBER

If you need help with this form call us on ☎ **0800 999 999.**

Before you start

If you have any questions, please call us on ☎ **0800 999 999**.

To avoid delays with your reimbursement, please read this form carefully.
Please complete all questions – if not applicable write N/A.
Post your completed application to PO Box 5054, Lambton Quay, Wellington.

Name

1. What is your name?

First name(s)

Surname or family name

Q2 note: *Give any other names that you use now or have used in the past (including your maiden name).*

2. Are you known by or have you used any other names?

☐ No ☐ Yes ▶ Please provide details below:

1.

2.

3. What gender are you? ☐ Male ☐ Female

Q4 note: *Please tick one box to show the title you want to be known by.*

4. What do you want to be called?

☐ Mrs ☐ Miss ☐ Ms ☐ Mr ☐ No title ☐ Other

Birth date

5. What is your date of birth?

Day Month Year

Address

Q6 note: *If you live in a rural area, a house number could include:*

- *RAPID number*
- *fire number*
- *emergency services number.*

6. Where do you live?

Flat/house no. Street name

Suburb City

Q7 note: *Mailing address includes:*

- *postal box (PO Box)*
- *rural delivery details*
- *C/O address.*

7. What is your mailing address (if different from above)?

If you live at a rural address please include your rural delivery details here:

8. How can we contact you?

Work phone Home phone Mobile phone

Email Fax

Tax number

9. What is your Inland Revenue tax number?

Claim details

Q10 note: *You can not claim for another person unless they are your dependent child or you are their authorised agent.*

If you are an agent you will need to send us a copy of your authorisation.

Please send a copy of your card with this form.

10. Who are you applying for?

Myself ☐ My dependent child/ren ☐ ▶ Please give details below:

Child's full name	Date of birth
1	/ /
2	/ /
3	/ /

11. Are any of these overcharges covered by ACC? ☐ Yes ☐ No

12. Please indicate if you have a High Use Health Card or a Pharmaceutical Subsidy Card.

☐ High Use Health Card ▶ Number

Commencement date (Day Month Year) Expiry date (Day Month Year)

☐ Pharmaceutical Subsidy Card ▶ Number

Commencement date (Day Month Year) Expiry date (Day Month Year)

Bank details

13. Are you currently receiving income support?

☐ Yes ▶ Your reimbursement will be paid into the same account

☐ No ▶ You MUST provide one of the following:
- a pre-printed bank deposit slip
- verification from your bank including their stamp in the panel on the left

14. What bank account do you want the reimbursement paid into?

Name of bank (eg ANZ) Name of branch (eg Lower Hutt)

Account name of

Account number (Bank Branch Account number)

Bank / Office use

Verified by .....

Important

15. Are all original receipts are attached?
Eftpos receipts are not acceptable ☐ Yes

16. How many receipts are you attaching?

17. Do you want the receipts returned to you? ☐ Yes ☐ No

The above information is true and complete.

Name (print) Client's signature Date (Day Month Year)

Office Use Only

Grant ☐ **Decline** ☐

Reimbursement for overcharges

	$
	$
	$
	$

Processor's signature Date (Day Month Year)

Authenticator's signature Date (Day Month Year)