Reimbursement of Health Overcharges application

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

To avoid delays with your reimbursement, please read this form carefully.

If you need any help completing the form, call us on **0800 999 999**.

Post your completed application to **PO Box 5054, Lambton Quay, Wellington 6145**

Tell us about yourself

If you've received a benefit or extra financial help from us before, write your client number here if you know it. This number can be found on your Community Services Card if you have one.

Client number ☐☐☐ ☐☐☐ ☐☐☐

Tell us your details

1 What is your full name?

First and middle names

Surname or family name

2 What date were you born?

Day Month Year

3 What is your Inland Revenue tax number?

☐☐☐☐☐☐☐☐☐

Tell us how we can contact you

4 Where do you live?

Flat/House number Street name

Suburb Town/City

HOW TO ANSWER Q4:
If you live in a rural area, flat/house number could include your RAPID number, fire number, emergency services number.

5 Is your mailing address different from where you live?

☐ No ☐ Yes **Tell us your mailing address**

HOW TO ANSWER Q5:
Mailing address can include a PO Box, rural delivery details, or C/O address.

HOW TO ANSWER Q6:
Please only give us contact details you'd like us to use.

6 How else can we contact you?

Tick the best way for us to first contact you

Home phone	( )	
Mobile phone	( )	
Other phone	( )	

7 Do you agree to get emails from us?

☐ No ☐ Yes **Tell us your email address** ☐ I don't have an email address

Claim details

8 Who are you applying for?

INFORMATION FOR Q8:
You can't claim for another person unless they're your dependent child or you're their authorised agent.

ATTACHMENT FOR Q13:
If you're an agent you'll need to send us a copy of your authorisation.

☐ Myself

☐ My dependent children **Please provide details below**

Child 1's full name

Date of birth (Day / Month / Year)

Child 2's full name

Date of birth (Day / Month / Year)

Child 3's full name

Date of birth (Day / Month / Year)

9 Are any of these overcharges covered by ACC?

☐ No ☐ Yes

10 Do you have a High Use Health Card?

☐ No ☐ Yes **Please give details below**

High Use Health Card number:

Start date: (Day / Month / Year)

Expiry date: (Day / Month / Year)

11 Do you have a Pharmaceutical Subsidy Card?

☐ No ☐ Yes **Please give details below**

Pharmaceutical Subsidy Card number:

Start date: (Day / Month / Year)

Expiry date: (Day / Month / Year)

Bank details

12 **Do you get income support payments from Work and Income?**

☐ No **Go to question 13**

☐ Yes **The reimbursement will be paid to the same account as your other payments.**

ATTACHMENT FOR Q13:
You need to provide proof of your bank account details, such as a bank statement or deposit slip.

13 **What bank account would you want your payments to be paid into?**

The account is in the name of:

The account number is:

Bank Branch Account number Suffix

Declaration and signature

The information I have given you is true and complete.

Applicant's name (print)

Applicant's signature

Date

Day Month Year

Checklist		
Are all the original receipts attached? (EFTPOS receipts are not acceptable.)	☐ No	☐ Yes
How many receipts are you attaching?		
Do you want the receipts returned to you?	☐ No	☐ Yes