Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1367
May 2026

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Bee or wasp venom allergy treatment

Initial application
Applications only from a relevant specialist. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

- [ ] RAST or skin test positive

and

- [ ] Patient has had severe generalised reaction to the sensitising agent

Renewal

Current approval Number (if known):..

Applications only from a relevant specialist. Approvals valid for 2 years.
Prerequisites(tick box where appropriate)

- [ ] The treatment remains appropriate and the patient is benefiting from treatment

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: .... Date: ....

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: **customerservice@health.govt.nz**