

Claim Form

PLEASE ATTACH ORIGINAL ACCOUNTS & RECEIPTS OR MEDICARE STATEMENTS

Enquiries Free Call 1800 603 603

Free Post to:
Police Health
Reply Paid 6111
ADELAIDE SA 5000

Fax claim 1800 008 554

Fax your receipts/paid accounts
up to a total of \$500

Police Health



YOUR HEALTH FUND

1

Member Details

Membership number

Surname Given Names

Postal Address Postcode

Return to me at
(Use only if different to above address)

Telephone: Hm Wk Mob

Email

2

Claim Details

Patient's Given Name	Date of Birth	Name of Provider / Dr.	Fee Charged	Account Paid? YES / NO	PromptPay* to Bank Account YES / NO
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

* Do you want Benefits for your paid accounts credited directly to your previously nominated financial account?
If account number not previously advised, please supply

BSB Account No.

Name of account Permanent details Yes No

3

Hospital Details (Please complete if any of the above services were rendered when in Hospital)

Patient's Name	Name of Hospital	Date of Admission	Date of Discharge
		/ /	/ /
		/ /	/ /

4

Adding a Newborn Child (Please complete this section if you wish to add a newborn child to your membership)

Surname Given Names

Date of Birth / / Sex Male Female

5

Declaration (Please ensure this section is completed)

In respect of the services claimed:

(a) Did the treatment result from an accident? Yes No

If yes, please provide details:

(b) Are you entitled to claim Third Party, Worker's Compensation, damages from any other source? Yes No

(c) I authorise Police Health to contact the Hospital or provider of any services for clarification of any details of the attached claim, if necessary.

(d) To the best of my knowledge the information supplied is true and correct.

Signed Date / /