

CLAIM FORM



ANCILLARY BENEFITS Complete questions 1, 2, 3, 6

ABN 95 159 348 533

MEDICAL GAP BENEFITS Complete questions 1, 2, 3, 4, 5, 6

1 MEMBERSHIP NUMBER [] [] [] [] [] [] [] [] COVER/TABLES [] F/S

SURNAME Mr./Mrs./Miss/Ms _____

GIVEN NAMES _____

POSTAL ADDRESS _____

_____ POSTCODE _____

Is this your permanent mailing address? YES NO CONTACT PHONE _____

Do you pay at/by: Branch Agent Direct Debit Payroll

If you pay at an Agency - Complete the following from your last membership receipt:

Date Issued/...../..... Receipt No. Amount paid: \$.....

2 **PATIENT AND SERVICE DETAILS - ALL QUESTIONS MUST BE ANSWERED**

Please ensure that all accounts are fully itemised. Lack of information may result in delay of payment. Only original or certified duplicate accounts will be accepted. Please do not submit photocopies as these will not be accepted.

Patient Name	D.O.B	Providers Name	Acc. Paid?

Do you require cheque : Yes No Cheque payable to: Yourself Doctor

or EFT (Please give details below)

(DEPOSITED DIRECTLY INTO BANK ACCOUNT VIA EFT - NOT AVAILABLE FOR CREDIT CARD ACCOUNTS)

Name Account held in:

Financial Institution:

BSB number (6 digits)

[] [] [] [] [] []

Bank account number (up to 10 digits only)

[] [] [] [] [] [] [] [] [] []

Privacy Statement At Latrobe Health Services our commitment to you is to handle your personal information in a way that is consistent with our Privacy Policy and our obligations under the National Privacy Principles. The collection of this information is necessary to process your health insurance claim. To enable benefits to be paid we may need to disclose this information to a hospital, medical and other health service provider with whom you have had or may have a treatment episode. We may also disclose your personal information to the member named as the policy holder (or any other person who lodges an authorised claim for benefits who would normally be the spouse of the member) where there is an entitlement to benefits under a family cover policy. If you do not provide the personal information requested about you or any dependant, the consequences may include our inability to process this claim. If you would like access to your personal information or more details concerning our information handling practices, please contact Latrobe Health Services on 1300 362 155.

3 Was the treatment the result of an accident? YES NO
If so, state date and give brief description of how accident occurred:
.....
.....

4 Are any of the services related to a compensation claim? YES NO UNKNOWN
(Past, present or pending.)

If inpatient services : Name of Hospital.....

Hospitalisation was from/...../..... to/...../.....
(Please submit the top portion of your Medicare Statement or original accounts with this claim).

5 Were you informed of the likely patient out of pocket costs in relation to these services?
Yes No Emergency Treatment

IMPORTANT: Your answer will affect what additional Medical Rebate you receive. Please contact our Member Service Centre for clarification 1300 362 155.

6 I declare that the given particulars are true and correct and hereby authorise Latrobe Health Services to obtain any information in reference to this claim.

Signature of Member Date/...../.....

CASH PAYMENTS ONLY - I ACKNOWLEDGE RECEIPT OF

..... \$.....

LATROBE BRANCH/AGENT USE ONLY :

Payee details	Amount	Cheque No
1.		
2.		
3.		
Assessed by:	Date	/ /

CLAIMS MAY BE LODGED FOR PAYMENT BY:

- Calling personally at any of our Branches for Ancillary & Medical Gap
- Calling personally at any of our Cash Claim Centres (cash limit is \$250) Ancillary only.
 - Your membership account/receipt or card must always be presented
 - Service hours are 9 am to 5 pm Monday to Friday (Except Public Holidays)
 Medical Gap claims may be lodged for settlement by mail.
- Posting your claim to Latrobe Health Services, P.O. Box 41, Morwell 3840

