



Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Claim Form

Membership No: \_\_\_\_\_  
 Daytime Phone No: \_\_\_\_\_  
 Mobile No: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Please attach all original accounts / receipts and any Medicare receipts (if applicable)**

Service Date	Patient's Full Name	Medicare Card No. (if applicable)	Item No.	Type of Service	Amount (\$A) Claimed	Paid (\$A) (please circle)
<i>Example 1/1/2008</i>	<b>John Smith</b>	<b>1234 56 789 0</b>	<b>23</b>	<b>GP Consultation</b>	<b>50.00</b>	<b>Yes / No</b>
						<b>Yes / No</b>
						<b>Yes / No</b>
						<b>Yes / No</b>
						<b>Yes / No</b>
						<b>Yes / No</b>
						<b>Yes / No</b>
						<b>Yes / No</b>
<b>TOTAL</b>					<b>\$</b>	

1. Is this claim the result of a workplace/public liability or motor vehicle accident? (please circle) Yes / No
2. If 'yes', the date of the accident was \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Is the patient entitled to any form of compensation, damages or payment as a result of the accident? (please circle) Yes / No
4. If 'yes' please provide details below:

I hereby declare and warrant that all the above information provided in connection with this claim is true and correct. I authorize the hospital and doctors and all medical service providers concerned with this claim to supply all information to IMAN Australian Health Insurance.

Member's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

