

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</i> 1/1/2008	John Smith	1234 56 789 0	23	GP Consultation	50.00	Yes / No
						Yes / No
						Yes / No
						Yes / No
						Yes / No
						Yes / No
						Yes / No
						Yes / No
TOTAL					\$	

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: ____/____/____