Claim Form

Please complete and send to:
PO Box 545, Strawberry Hills NSW 2012 or email enquiries@transporthealth.com.au

ORIGINAL ACCOUNTS AND / OR RECEIPTS MUST BE ATTACHED.
Benefits are not payable under any of the tables of the Health Fund if the claim for benefits is not lodged with the Fund within a period of 2 years from the date the relevant service was rendered.

Office use only: Claim Number ____ Verified by ____ Date ____

1. Member Details

Member number ____ Family Name ____ Given Names ____

Address ____ Postcode ____

Email Address ____

Is this a new address? ☐ Yes ☐ No Home ____ Work ____ Mobile Ph ____

This section must be completed or claim will not be processed.

If the service is for a dependent child between 21 and 25 years of age, is he/she a full time student? ☐ Yes ☐ No

Are any of the services claimed associated with an accident or injury? ☐ Yes ☐ No

Are you entitled to claim damages or compensation for any of these services? ☐ Yes ☐ No

If yes, please give details... ____

2. Claims Detail

Patient's Given Name	Date of Birth	Relationship to Member	Date of Service	Fee Charged	Provider	Office use only	
						Item Number	Benefit

Are any of the services shown above related to treatment received whilst an in-patient in hospital? ☐ Yes ☐ No **If yes please give details:**

Name of Patient ____ Name of Hospital ____ Admission / Discharge Dates / / to / /

3. Payment Details

Have these accounts been paid? ☐ Yes ☐ No Cheque will be made payable to Provider.

If YES, please select payment option.

1) ☐ PREVIOUSLY NOMINATED ACCOUNT

If not previously nominated, please give details below for funds to be directly credited to your bank account (all future benefits payable to the Member will be automatically credited to this account). **ENSURE DETAILS ARE CORRECT. NOTIFY FUTURE CHANGES IMMEDIATELY.**

Financial Institution ____ Branch ____ BSB Number ____ **Account Number** ____

2) ☐ **CHEQUE** Made payable to: ☐ Member ☐ Spouse ☐ Other In the name of ____

4. Declaration by Member

I declare that the information shown is true and correct. I understand there are penalties for misleading or false information.

I authorise the Transport Health Fund to contact the provider of the services if clarification of accounts/receipts is required for assessment purposes.

Signature ____ Date ____

Transport Health Pty Ltd (ABN 39 099 028 127) ("Transport Health")