

Claim Form

Forward your claims to us by:

Mail PO Box 931 Burnie, Tasmania, 7320 **Freefax** 1800 643 969

In person at our office 50 Marine Terrace, Burnie **Any queries phone** 1800 804 950

healthcare
insurance

Office Use Only

Claim number

Benefit

Assessed by

Date

Membership Details

Member number

Title

Date of birth

Sex

Male

Female

Surname

Given names

Postal address

Street / PO Box

City / Suburb

State

Post Code

Home phone

Work / Day phone

Electronic Funds Transfer (EFT) Details

You are only required to complete the following if you have not already provided us with your account details or you wish to change the details that we currently have recorded for you.

Do you wish to have your benefit deposited directly into a bank account via EFT?

Yes

No

Name of Financial Institution

Branch

Name of account holder

BSB number

Account number

Details of Services

| Date of service | Patient - Given name | Type of service | Name of provider | Cost of service | Account paid |
|----------------------|----------------------|----------------------|----------------------|----------------------|--|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Was the patient an in-patient of a hospital or day facility for any of the above services?

Yes

No

If "yes" what was the name of the hospital?

Date of admission

Date of discharge

Claimant Declaration

THIS SECTION MUST BE COMPLETED BEFORE CLAIMS WILL BE PAID

- Are the services being claimed related to an accident, illness or injury which has, or may result in the payment of compensation or damages? Yes No
- I hereby claim HCl benefits for the services to which this claim relates, and I declare that I have incurred the expenses for these services. The services are not for the purpose of life insurance, superannuation, admission to a friendly society, mass immunisation or connected with the patient's employment. The services being claimed are not subject to a compensation or damages action. To the best of my knowledge and belief all the information in this claim is true and correct. I authorise HCl to contact the provider if clarification of accounts/receipts is required for assessment purposes.

Signature of Claimant

Date

Privacy

The information provided by you on this claim form is solely collected for the purpose of assessing your eligibility and effecting the payments of benefits to you. Any financial information provided is not divulged to any other individual organisation. You can read the full privacy statement by visiting the HCl website at www.hcilt.com.au or by requesting a copy on freecall 1800 804 950.