Claim Form

Forward your claims to us by:

Mail PO Box 931 Burnie, Tasmania, 7320 **Fax** 1800 643 969 **Email** enquiries@hciltd.com.au
In person at our office 25 Cattley Street, Burnie **Any queries phone 1800 804 950**

healthcare insurance

Office Use Only
Claim number | Benefit | Assessed by | Date / /

Membership Details

Member number
Title
Surname
Postal address
Date of birth / /
Sex Male Female
Given names
Phone number
Email

Electronic Funds Transfer (EFT) Details

Do you wish to have your benefit deposited directly into a bank account via EFT? Yes No

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 for this to be a permanent change to the policy Credit details? Yes No

Please note for this to be a permanent change the policyholder, or authorised person must sign this Form.

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	
/ /					Yes	No
/ /					Yes	No
/ /					Yes	No
/ /					Yes	No
/ /					Yes	No
/ /					Yes	No
/ /					Yes	No
/ /					Yes	No
/ /					Yes	No

Was the patient an inpatient 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

1. 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
2. I hereby claim HCI 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 HCI to contact the provider if clarification of accounts/receipts is required for assessment purposes.

Signature of Claimant or agent | **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 HCI website at hciltd.com.au or by requesting a copy by calling 1800 804 950.

Health Care Insurance supports the use of Australian made paper.

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