If you prefer, you can use the HCi Claiming App instead of this form. Just download it from your favourite app store.

Health Care Insurance

Claim form

Forward your claims to us by completing this form and returning it with your receipts/invoices to HCi, PO Box 931, Burnie TAS 7320, enquiries@hciltd.com.au, or in person at our office 25 Cattley Street, Burnie.

Please call us if the services being claimed related to an accident, illness or injury which has, or may result in the payment of compensation or damages.

Member details

Member number

Family name

Given name(s)

Email

Mobile

Date of birth dd / mm / yyyy

Please let us know of any additions to your family or new address details via OMS or calling us.

Details of services

You can provide additional service details on the back of this form.

	Date of service	Patient - Given name	Type of service	Name of provider	Tick if inpatient	Cost of service	Tick if paid
1	dd / mm / yyyy						
2	dd / mm / yyyy						
3	dd / mm / yyyy						
4	dd / mm / yyyy						

Electronic Funds Transfer (EFT) details

Complete the following only if you have not given us your account details or you want to change the details currently recorded for you.

Do you wish this to be the permanent credit details for your policy? **Yes** (The policyholder or authorised person must sign this form.) **No**

Name of account holder

BSB number

Account number

Declaration

This section must be completed before claims will be paid.

- I have attached all relevant receipts/invoices and declare that these services were received by the named patient(s) within the last two years. 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. If the services relate to an accident, illness or injury which has, or may result in a compensation or damages payment, I have called HCi to discuss.
- To the best of my knowledge, all the above information correct. I authorise HCi to contact the provider if any additional information is required.

The information collected on this form is solely for assessing your eligibility and managing your HCi cover. Any financial information provided is not divulged to any other individual or organisation. You can read the full privacy statement on the HCi website or by calling 1800 804 950 to request a copy.

Signature of member or agent

Date dd / mm / yyyy

Office use only

Claim number

Total payment

Assessed by

Date dd / mm / yyyy