

OSHC Claim Form



1. Your details USE BLACK PEN ONLY AND PRINT IN UPPERCASE

Membership number	Title	First names
<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	Date of birth (DDMMYY)	
<input type="text"/>	<input type="text"/>	
Street address	<input type="text"/>	
Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone number	Mobile phone number	
<input type="text"/>	<input type="text"/>	
Email address	<input type="text"/>	

Do you have a Reciprocal Medicare (yellow) card? YES NO If YES, please provide the following details.

Name on card (please write your name exactly as it appears on your Medicare card)

Card number Expiry date (MMYY)

2. Hospital service details Please complete this section if any of the services were performed while you were an inpatient in hospital.

Name of hospital	Nature of illness	Date of admission	Date of discharge
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Statement by policy holder Are you able to make a claim for payment of these services from another party or insurer regarding workers compensation, motor vehicle accident, school injury, medical negligence, public liability or any other form of compensation? YES NO

If yes, ahm won't pay for services and treatment which are covered by compensation and damages provisions of any kind unless such services, treatment or transportation are covered by OSHC extras cover.

4. Details of claim Make sure you attach your original account or receipts to this claim form. They will not be returned to you.

Have you paid for this service? Y/N	Patient's first name	Date of service
1. <input type="text"/>	<input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>	<input type="text"/>
Provider name	Provider number	Type of service
1. <input type="text"/>	<input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>	<input type="text"/>

5. Details for payment of benefits Please indicate your preferred method of payment by crossing (x) one of the boxes.

Direct credit to your bank account (Please complete the bank details below)

Name of financial institution	Address of financial institution	
<input type="text"/>	<input type="text"/>	
Name of account holder	BSB number	Financial institution account number
<input type="text"/>	<input type="text"/>	<input type="text"/>

By cheque to your postal address (NOTE: Cheques for unpaid accounts will be made payable to the provider of the service)

6. Declaration by policy holder I declare that the information on this form is true and correct. I authorise ahm to check any of these services with the relevant provider and if any benefits have already been paid from another insurer. I authorise ahm to confirm relevant information with my educational institution or DIAC.

Policy holder's signature

SIGN HERE	DATE: / /
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HAVE YOU ATTACHED YOUR RECEIPTS?



**PLEASE STAPLE OR PIN
YOUR RECEIPTS HERE**

**If you need help completing this form
call the interpreter service on
1800 006 745**

Your privacy

Australian Health Management Group Pty Limited (ahm) is subject to the *Privacy Act* 1988 and complies with the principles for handling your personal information. ahm's privacy policy can be viewed on the ahm web site www.ahm.com.au or you can call us on 134 246 to have a copy of the policy posted or emailed to you.

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