

# 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	
<input type="text"/>	<input type="text"/>	

If you have changed address since your last contact with ahm, please cross this box  and complete the details in the address section overleaf.

## 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 Do you intend 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, please give details.

Were you travelling to or from work?  YES  NO

## 4. Details of claim Your original account/receipts/Medicare statement of benefits must accompany this claim. These will not be returned to you.

	Provider paid Y/N	Patient Code**	Patient's first name	Date of service
1.	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

  

	Provider name	Provider number	Type of service - Please write the appropriate code in the box.
1.	<input type="text"/>	<input type="text"/>	<input type="text"/> Chiropractic - 1
2.	<input type="text"/>	<input type="text"/>	<input type="text"/> Physiotherapy - 2
3.	<input type="text"/>	<input type="text"/>	<input type="text"/> Podiatry - 3
4.	<input type="text"/>	<input type="text"/>	<input type="text"/> Acupuncture - 4
			<input type="text"/> Naturopath - 5
			<input type="text"/> Osteopathy - 6
			For all other claim types, please write the name eg. Dental, Optical etc.

\*\* As shown on membership card

## 5. Agent's authority If you're authorising another person to collect cash benefits, complete this section before your claim is lodged.

Agent's signature	Policy holder's signature
<input type="text"/>	<input type="text"/>

## 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 by previous health insurers. I acknowledge that ahm may use the information on this claim form to assess and process this claim, or for other purposes related to this claim as outlined in the ahm Privacy Policy. I confirm the services submitted on this claim form were performed by the providers, and received by the persons named on this form. I declare these services cannot be claimed from any other source unless specified in question 3 above.

Policy holder's signature  DATE: / /



