Australian Health Management OSHC
CLAIM FORM

1 Your details

USE BLACK PEN ONLY AND PRINT IN UPPERCASE

Membership number | Title | First names

Surname | Date of birth (D D M M Y Y)

Street address

Suburb | State | Postcode

Email

Phone | Mobile phone

Passport number | Country of Origin

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 (D D M M Y Y) | Date of discharge (D D M M Y Y)

3 Statement by member

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, we won't pay for services and treatment which are covered by compensation and damages provisions of any kind unless such services, treatment of transportation are covered by ahm 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 (D D M M Y Y)
1			
2			

	Provider name	Provider number	Type of service
1			
2			

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

Name of account holder | BSB number

[ ] By cheque to your postal address (NOTE: All Overseas Student Health Cover unpaid accounts will be paid direct to provider.)

6 Declaration by member

I declare that the information on this form is true and correct. I authorise Australian Health Management OSHC to check any of these services with the relevant provider and if any benefits have already been paid. I acknowledge that ahm OSHC 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 OSHC 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.

Member's signature

SIGN HERE | Date (D D M M Y Y)

0122E

HAVE YOU ATTACHED YOUR RECEIPTS?

Please staple or pin your receipts here

Mail your claim form and medical receipts, no stamp required to:

ahm OSHC
Reply Paid 88995
Wetherill Park Bc NSW 2164

If you need help completing this form call the interpreter service on

1800 006 745

Your privacy We are subject to the Privacy Act 1988 and your personal information is managed in accordance with the ahm OSHC Privacy Policy which can be viewed at **ahmoshc.com.au.**

Reply Paid 88995, Wetherill Park Bc NSW 2164 **Phone: Australia** 134 148 **Outside Australia** (+61) 3 9862 1095
Email: oshc@ahm.com.au **Web:** ahmoshc.com.au

'Australian Health Management OSHC' also known as 'ahm OSHC' is a business of Medibank Private Limited ABN 47 080 890 259.