

Member Claim Form (Mail Claims)



Member No.:

Name: D.O.B.

Address:

State: Postcode: Phone:

Has the Account been Paid?: Yes No (Enter below the name of Doctor/Provider for Cheque to be made out to)

Patient Name	Service Provider	Hospital Name (if applicable)	Admission date
...../...../.....
...../...../.....
...../...../.....
...../...../.....
...../...../.....
...../...../.....

Payment method: Cheque EFT (As per the account details already on file) EFT (As per the following details)

Account Holder: Financial Institution:

BSB - Account Number

Would you like Latrobe to keep these details on file for any future payments? Yes No

Ensure all accounts are fully itemised. Only original or certified duplicate accounts will be accepted.

Was the service/s the result of an accident? Yes No

Do you have an entitlement to compensation in relation to the service/s? Yes No

Medical benefits – were you informed of out of pocket costs in relation to the service/s?
 Emergency treatment Yes No

**Important: Your answer may affect benefits payable.
 Please contact our Member Service Centre for clarification on 1300 362 144**

Declaration

- I declare that:
- The information provided is true and correct.
 - I hereby authorise the providers concerned to supply any information required to validate this claim.

Member Signature Date: / /

Mail claim to: Latrobe Health Services, Reply Paid 41, Morwell VIC 3840
Phone 1300 362 144

Office Use	Claim No.		
	Payee.....	Cheque No.....	Amount \$.....
	Payee.....	Cheque No.....	Amount \$.....
	Payee.....	Cheque No.....	Amount \$.....
	Payee.....	Cheque No.....	Amount \$.....
	Assessed By:.....	Date:...../...../.....	

Privacy Statement

At Latrobe Health Services our commitment to you is to handle your personal information in a way that is consistent with our Privacy Policy and our obligations under the National Privacy Principles. The collection of this information is necessary to process your health insurance claim. To enable benefits to be paid we may need to disclose this information to a hospital, medical and other health service provider with whom you have had or may have a treatment episode. We may also disclose your personal information to the member named as the policy holder (or any other person who lodges an authorised claim for benefits who would normally be the spouse of the member) where there is an entitlement to benefits under a family cover policy. If you do not provide the personal information requested about you or any dependant, the consequences may include our inability to process this claim. If you would like access to your personal information or more details concerning our information handling practices, please contact Latrobe Health Services on 1300 362 155.