Latrobe Health Services Limited
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Member Service enquiries: 1300 362 144

Member Claim Form

Please read the following information before completing this form

- **Benefits are only payable for services and products provided in Australia**
- **Original, fully itemised accounts and/or receipts must accompany this claim**
- **Claims must be lodged with Latrobe within two years of the date of service**

Both sides of this form must be completed for your claim to be processed

Please note for Medical Claims – this claim form is only required if you're submitting the Medicare Statement of Benefit by email.
If you're submitting this form by mobile app or through a Medicare office no claim form is required – please refer to "Claiming your medical fees after hospital" fact sheet for more detail.

Claimant details

Member No.: ☐☐☐☐☐☐☐☐

Name _____ D.O.B. _____

Address _____

Suburb _____ State _____ Postcode _____ Phone _____

Email (mandatory) _____

Informed Financial Consent (IFC)

For information regarding medical gap claims, please refer to page 2 *Claims for medical services* section

Were you informed of out-of-pocket expenses in relation to the medical service/s? Y ☐ N ☐

If no, was this an emergency admission to hospital? Y ☐ N ☐

Electronic Funds Transfer (EFT)

Benefits will be paid by EFT into your account as nominated below

☐ EFT as per current account details on your membership, (funds cannot be electronically transferred to a credit card)

☐ EFT as per the details below

Please complete all financial details. If all details are not completed, your payment could be delayed.

Account holder: _____

Financial institution: _____

BSB No: ☐☐☐-☐☐☐ Account No: ☐☐☐☐☐☐☐☐☐

Would you like us to keep these details on file for all future payments for this membership? Y ☐

Claimant declaration and signature

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

Claimant signature: _____ Date: _____

Extras and medical gap claims over the page

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 state and federal privacy legislation. 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 or other health provider with whom you have had 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 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, contact us on 1300 362 144.

Claims for medical services provided whilst an inpatient in hospital

Government legislation does not allow Latrobe to contact Medicare on your behalf.
If you have any queries regarding Medicare's assessment of your claim, please contact them on 132 011.

For more information, please refer to Latrobe Health Services' "Claiming your medical fees after hospital" fact sheet for more detail, available at latrobehealth.com.au.

Medical gap claims for services provided whilst an inpatient in hospital

Patient name _____ Date of admission _____

Hospital name _____

	Is the account paid in full?	Result of an accident?	Related to compensation?
▶ Provider name _____	Y ☐ N ☐	Y ☐ N ☐	▶Y ☐ N ☐
▶ Provider name _____	Y ☐ N ☐	Y ☐ N ☐	▶Y ☐ N ☐
▶ Provider name _____	Y ☐ N ☐	Y ☐ N ☐	▶Y ☐ N ☐
▶ Provider name _____	Y ☐ N ☐	Y ☐ N ☐	▶Y ☐ N ☐

Extras claims

	Is the account paid in full?	Result of an accident?	Related to compensation?
▶ Patient name _____ Provider name _____	Y ☐ N ☐	Y ☐ N ☐	▶Y ☐ N ☐
▶ Patient name _____ Provider name _____	Y ☐ N ☐	Y ☐ N ☐	▶Y ☐ N ☐
▶ Patient name _____ Provider name _____	Y ☐ N ☐	Y ☐ N ☐	▶Y ☐ N ☐
▶ Patient name _____ Provider name _____	Y ☐ N ☐	Y ☐ N ☐	▶Y ☐ N ☐

Clear Form Print Form Save Form

Office use only

Claim no _____ Date _____ Checked by _____