Latrobe HEALTH SERVICES
EveryBody benefits from our health cover

Latrobe Health Services Limited
ABN 94 137 187 010
Reply Paid 41, Morwell VIC 3840
Email: info@lhs.com.au
Website: latrobehealth.com.au
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 do not staple, pin or tape your accounts to this form

Claimant details

Member No.: ☐☐☐☐☐☐☐☐

Name ______________________ D.O.B. ______________

Address ______________________________________

Suburb ______________ State ________ Postcode ________ Phone ______________

Informed Financial Consent (IFC)

For information regarding **medical gap claims**, please refer to the **Just Ask!®** section over the page

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 is unsuitable, please mail a cheque to me

☐ 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, please contact us on 1300 362 144.

Private Health Insurance Code of Conduct™

Latrobe Health Services
proudly supports and complies with the
Private Health Insurance Code of Conduct

MEMBERS OWN HEALTH FUND

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.

If you have a **paid account**

Visit your local Medicare branch to receive your Statement of Benefits, which can then be lodged with us with your completed *Latrobe Claim Form*. Alternatively, Medicare will electronically lodge the claim with Latrobe on your behalf.

Please note: If you have been charged above the Medicare Benefit Schedule (MBS) fee and the claim is electronically transmitted to Latrobe, to enable us to pay any additional benefits above this fee, we require you to have answered the IFC question on page 1 of this form. If no IFC has been provided, Latrobe can only pay up to the MBS fee.

If you have an **unpaid account**

1. You will need to complete a Medicare Claim Form, a Medicare Two-way Claim Form and a Latrobe Claim Form - ensure you have answered the IFC question on page 1.
2. Submit your accounts and Claim Forms by mail or in person to Latrobe
3. Latrobe will forward your claim to Medicare on your behalf
4. Medicare will send their payment directly to you payable to the Provider
5. Medicare then sends the claim details to Latrobe for completion
6. Latrobe will assess its portion of the claim and send payment directly to you payable to the Provider

Please note: if you have paid a separate out-of-pocket cost, please ensure that a copy of this is submitted to Latrobe to ensure maximum benefits are paid.

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 ☐

Office use only

Claim no ______________ Date ______________ Checked by ______________

Cheque No. ______________ Payee ______________ Amount: $ ______________

Cheque No. ______________ Payee ______________ Amount: $ ______________

Cheque No. ______________ Payee ______________ Amount: $ ______________

Cheque No. ______________ Payee ______________ Amount: $ ______________