Phoenix Health Fund Limited

A Registered Health Benefits Organisation
A.B.N. 93 000 124 863

HEALTH INSURANCE CLAIM FORM

INDUSTRIAL DRIVE, MAYFIELD 2304
P.O. BOX 156, NEWCASTLE, 2300
TELEPHONE: (02) 4935 5738, (02) 4935 5741
FREECALL 1 800 028817
FACSIMILE: (02) 4968 2229
WEBSITE COPY: www.phoenixhealthfund.com.au

Please use BLOCK LETTERS

MEMBERSHIP NUMBER ☐☐☐☐☐☐

FAMILY NAME _____

GIVEN NAMES _____

ADDRESS _____

_____ **POST CODE** _____

OFFICE USE ONLY

Number of Claim Lines:

Cheque Number:

Audited by:

Pin Accounts & Receipts Here

Please do not staple or tape accounts to claim form.

Patient Given Name	Name of Provider	Type of Service	Item Number	Date of Service	Paid Yes	Paid No
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

WHEN A RECEIPT IS NOT ATTACHED A CHEQUE WILL BE MADE PAYABLE TO THE PROVIDER OF THE SERVICE.
N.B. All claims must be accompanied by original itemised accounts (and receipts if accounts have been paid). Photocopies not acceptable.

Adding a newborn child to your family membership - Name:	Gender M/F	Date of Birth

ELECTRONIC FUNDS TRANSFER (EFT) DETAILS

1. Do you want the benefit to be deposited directly into a financial institution account via EFT? Yes ☐ No ☐
   (This option is only available for paid accounts. Claims cannot be credited to a credit card account.)
2. BSB Number (6 digits in total) ☐☐☐ - ☐☐☐ Financial Institution account number ☐☐☐☐☐☐☐☐☐
3. Name the account is held in: _____
4. Financial Institution: _____ Branch: _____
5. A Statement of Benefit will be issued automatically.

IN-HOSPITAL SERVICES: Fund Medical Gap benefits are only claimable where services are provided to an admitted patient of a hospital or approved day hospital facility. All other medical services are claimable through Medicare only.

HOSPITALISATION: Please complete this section for medical gap claims for services received in hospital.

Hospital Name:

Admission Date: *Discharge Date:*

PLEASE COMPLETE IF ANY OF THE SERVICES WERE FOR A STUDENT DEPENDANT, AGED 21 YEARS OR OVER:-

Name:.....

Educational Institution: .....

I hereby claim benefits for the professional services to which this claim relates, and I declare that:

- I consent to the collection, use and disclosure of information provided as part of this claim in accordance with the Privacy Policy Statement of the Phoenix Health Fund.
- There is no entitlement to claim compensation or damages from any other source;
- The services were not for the purpose of health screening, superannuation entry or a health examination requested by an employer;
- I authorise the Fund to contact the provider of any professional service for clarification of any details in this claim.

Signature of Claimant .....

Date .....