# CLAIM FORM

Health

Please use black pen and print upper case.
Avoid contact with the edge of the box. A B C D

Please complete all details (where applicable) and attach full itemised accounts/receipts.
You may email the completed form with receipts to Health.Claims@aia.com.au

## Member details

Member surname

Member number

## Claim details

Please enter all details of claim that are shown on invoice/receipt.

| | Patient first name | Patient date of birth | Provider number | Service date |
|---|---|---|---|---|
| Eg | J O H N | D D / M M / Y Y | 0 1 1 2 3 4 5 B | D D / M M / Y Y |
| 1 | | / / | | / / |
| 2 | | / / | | / / |
| 3 | | / / | | / / |
| 4 | | / / | | / / |
| 5 | | / / | | / / |
| 6 | | / / | | / / |
| 7 | | / / | | / / |

## Compensation

Are the charges in this claim recoverable as damages, compensation or benefit under any Repatriation, Worker's Compensation, TAC, Social Services or other Acts, Rules and Regulations, or from any other Third Party?

☐ No ☐ Yes (provide details)

## Direct credit details

**(If these details are completed, they will be used for this claim and all future claims, unless you advise us otherwise.)**

Account name

BSB number /

Account number

## Declaration

I declare that the information on this form is true and correct. I authorise AIA Health to check any of these services with the relevant providers and authorise AIA Health to contact the provider to obtain any necessary information to either verify or audit this claim.
I declare these services cannot be claimed from any other source unless specified in the compensation section of this form.

Member Signature

Date / /