AIA Health Insurance
CORPORATE

HEALTHIER, LONGER, BETTER LIVES

APPLICATION TO CLAIM TRAVEL AND ACCOMMODATION EXPENSES

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

To make a claim, the round trip must be at least 200 km within Australia.
For more information on eligibility please refer to the Fact Sheet in your online Member Portal or our Member Guide. Alternatively, call us on 1800 161 218.

1. Your details

Membership number

Mobile

Date of birth (DD/MM/YYYY) / /

Title

Member first name

Member surname

Title

Patient first name

Patient surname

2. Claiming for travel (capped at 15 cents/km for travel)

Return distance between home and hospital km

Type of travel (car/train/bus/plane) for journeys of over 200 km

Date travel commenced (DD/MM/YYYY) / /

Return date (DD/MM/YYYY) / /

I have attached a receipt for travel (petrol dockets are not required in the case of car travel). ☐ Yes

3. Claiming for accommodation (capped at $50 per day)

First date of accommodation (DD/MM/YYYY) / /

Last date of accommodation (DD/MM/YYYY) / /

Date of hospital admission (DD/MM/YYYY) / /

Date of hospital discharge (DD/MM/YYYY) / /

Name of hotel/motel where you/your carer stayed

I have attached a receipt for my accommodation. ☐ Yes

4. Carer details

Was a carer required to support the patient's travel, or provide support before and after hospitalisation? ☐ Yes ☐ No

Carer's name

Continued on next page

5. Declaration (to be completed by your GP or medical specialist)

I confirm that, in my opinion, the journey undertaken is/was necessary to receive hospital treatment because treatment is/was not available locally. ☐ Yes ☐ No

I confirm a carer was required to support the patient. ☐ Yes ☐ No

Signature of GP/medical specialist

Date (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

Title ☐☐☐☐ First name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Provider number of GP/medical specialist
☐☐☐☐☐☐☐☐☐☐☐☐

6. 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.

Signature of member (electronic signature accepted)

Date ☐☐/☐☐/☐☐☐☐

Once the form is completed, please return via email: corporatehealth.claims@aia.com.au or post to AIA Health, PO Box 7302, Melbourne VIC 3004