

claim form

Please return to: Central West Health Cover. PO Box 10860, Kalgoorlie WA 6433. Telephone: 133 206

Section One Member Details

Membership Number: _____

Member's Surname: _____ Given Name(s): _____

Member's Residential Address: _____
_____ Postcode: _____

Is this your permanent address for mailing purposes? Yes No

If no, what is your permanent postal address?

Telephone Home: _____ Business: _____ Mobile Number: _____

Fax Number: _____ Email: _____

Section Two Claim Details

Patient's Full Name: _____ Has the account been paid? Yes No

Did the treatment result from an accident? Yes No

Do you have an entitlement to claim compensation or damages? Yes No

Are you a permanent resident of Australia and entitled to full Medicare benefits? Yes No

If your claim relates to services provided while in hospital, you must also complete the Gap Claim-Details.

Ambulance Accounts

Do you hold a Pensioner Concession Card? Yes No

Are you entitled to claim benefits from your home state/territory ambulance scheme?

(Not applicable in all states/territories) Yes No

Section Three Gap Claim Details

Medicare Number	Exp Date	Hospital Name	Date Admitted	Date Discharged
_____	___/___/___	_____	___/___/___	___/___/___
_____	___/___/___	_____	___/___/___	___/___/___

Important: All in-patient hospital accounts must be sent direct to Central West Health Cover together with informed financial consent or quote from your Medical Practitioner. Gap Cover benefits will only be paid if the account has **not** been processed by Medicare.

Please note: Attach original detailed accounts for all services (if the account has been paid, also attach receipt). Facsimiles or photocopies of accounts, receipts or claim forms are not acceptable. Ensure your membership is paid up to at least the date of treatment. Claims must be lodged within two years of the date of service. Agency cash claims are limited to \$400. Central West Health Cover is unable to pay on part accounts. Accounts must be unpaid or fully paid.

Section Four Easy Claim - Direct Refund

Please complete this section if you wish to have your benefits payable credited directly to your nominated bank account (excludes credit cards). This authority will remain in force until it is changed or cancelled by you.

Name of Financial Institution: _____ Branch of Financial Institution: _____

BSB Number: _____ Account Number: _____

Account Name: _____

Signature: _____ Date: ___/___/___

Section Five Declaration

I declare the information shown on this form is true and correct and is not in respect of any injury or ailment where there is or may be a right to claim payment (including settlement) of damages or compensation of any kind. I authorise Central West Health Cover to contact the Provider of any service if clarification of details is required.

Signature: _____ Date: ____ / ____ / ____

Section Six Authority to Collect Benefits

Complete this section if someone is collecting on your behalf.

I authorise the person whose signature I have witnessed here to collect cash due to me in respect of this claim.

Authorised Person's Signature: _____ Date: ____ / ____ / ____

Authorised Person's Name: _____ Member's Signature: _____

Cash Benefit Refund

Amount Received: \$ _____ Date: ____ / ____ / ____ Claimant's Signature: _____

Section Seven Privacy Statement

Central West Health Cover will use the information you supply on this form and the information we collect from third parties in connection with your claim (see the declaration in section 5 above), to assess and process your claim. When you make the claim you consent to Central West Health Cover collecting related sensitive information directly from those third parties or, if you are not the recipient of the treatment or service which is the subject of the claim, you give consent on behalf of that recipient.

The personal information Central West Health Cover collect may be disclosed to our related companies. Central West Health Cover is also obliged by the Private Health Insurance Act 2007 to maintain certain transaction records and make those records available to the Private Health Insurance Ombudsman, the Department of Health and Ageing, the Private Health Insurance Administration Council and Medicare. We will disclose this and any other information as required by law. We may also disclose certain personal information to your bank or financial institution if you choose to have your benefit paid by direct credit, and to any person you authorise to collect your benefit on your behalf.

If you do not provide personal information, which is required, or give the authority in the declaration in section 5 above, Central West Health Cover may not be able to process your claim. In most circumstances you have a right to access any personal information, which we collect and hold about you. Please contact us if you wish to access your personal information. We may deny your request in some circumstances and if we do this, we will tell you why.

More information about the way we handle personal information is detailed in our Privacy Policy, which is available at centralwesthealth.com.au or on request by calling 133 206.