Accident claim form

Use this form to claim under Accident Override. We need this information to assess whether the injury is the result of an accident* and whether we will pay towards the cost of your hospital treatment. Accident Override is not available on all covers, so check your product guide for more information.

What you need to do
You need to complete the form and return it to us. Where possible, you should send us this form before arranging hospital treatment. If you are admitted in an emergency situation, complete and submit the form as soon as possible after the treatment.

If you're admitted before we've assessed your claim under Accident Override, make sure you ask your hospital and your doctors to explain what out-of-pocket expenses you could incur, as these costs could be significant.

What is Accident Override?
Services which are normally Restricted or Excluded services will be treated as Included services where you require hospital treatment as the result of an accident that occurred after joining the cover.

Section 1: Accident compensation

Could you be entitled to compensation from another source? (e.g. a claim with your state's Workers Compensation authority or motor vehicle accident authority or a claim against some other party.)

☐ **Yes** ☐ **No**

You may be contacted by our Customer Service Team to provide additional information about your claim.

Section 2: Member details (for the member who was injured)

Member number: _____ First name(s): _____

Surname: _____ Date of birth: _____ / _____ / _____

Residential address: _____

_____State: _____ Postcode: _____

Mobile phone number: _____ Home phone number: {____} _____

Section 3: How should we contact you?

Once we've received a completed Accident Claim Form, we'll assess if you're eligible to receive benefits. Please indicate below if you'd like to be notified of this decision by email or post.

☐ Email address: _____

or

☐ Postal address (if different from above): _____

Section 4: Details of the claim

Date of accident: _____/_____/_____ Time of accident:

_____ Date of admission (if admitted): _____/_____/_____

Is this the first admission for this injury?

☐ **Yes** ☐ **No**

Please describe how the injury occurred. If the accident involved a vehicle, please indicate whether you were the driver, a passenger, a pedestrian, a cyclist or another road user.

_____

_____

_____

Please describe the injury and indicate the part of your body affected (e.g. left shoulder, index finger):

_____

_____

_____

I understand that ahm requires information from the health practitioners nominated in sections 5 and 6 (and other health practitioners involved in that care) in order to assess whether benefits are payable towards the relevant hospital treatment. I consent to, and direct, these health practitioners (and any other health practitioners involved in that care) to provide ahm with any information as may be necessary for ahm to conduct its assessment. I authorise ahm to collect, use and disclose relevant personal information for the purpose (and related purposes) of assessing the claim, including to determine whether the claim may be subject to compensation.

I declare that the information I am providing is true and correct.

Signature of member or Parent/Guardian: _____Date: _____ / _____ / _____

Section 5: To be completed by the referring practitioner

This section must be completed by the medical practitioner who referred you to the specialist providing the hospital treatment.

Our member (nominated in Section 2) has indicated that they require treatment as a consequence of an accident. ahm requires the following information to determine if our member is eligible for treatment under their policy. Our member has consented to the provision of this information. Thank you for completing this section promptly - this will help us to finalise our member's claim.

Injury requiring treatment: _____

_____

_____

Date of first consultation: _____/_____/_____ Date of first admission for this injury, if admitted: _____/_____/_____

What was the nature of the injury and the body site involved? _____

_____

_____

What is the likely course of treatment required? _____

_____

_____

Do you consider the injury to be consistent with the description of the accident in section 4?

☐ **Yes** ☐ **No**

Comments: _____

_____

_____

Practitioner's name: _____ Practitioner type: _____

Provider number: _____

Address: _____

_____

Email: _____ Phone number: ( ) _____

I declare that the information I am providing is true and correct and any opinion above is my true opinion.

Signature: _____ Date: _____

Section 6: To be completed by the treating specialist

All members: this section must be completed by the specialist providing the hospital treatment

Our member (nominated in Section 2) has indicated that they require treatment as a consequence of an accident. ahm requires the following information to determine if our member is eligible for treatment under their policy. Our member has consented to the provision of this information. Thank you for completing this section promptly – this will help us to finalise our member's claim.

Injury requiring treatment: _____

_____

_____

Date of first consultation: _____ / _____ / _____ Date of first admission for this injury, if admitted: _____ / _____ / _____

What was the nature of injury and the body site involved? _____

_____

_____

What is the likely course of treatment required? _____

_____

_____

In your opinion, what is the likely duration of the likely course of treatment? _____

_____

_____

Do you consider the injury to be consistent with the description of the accident in section 4?

☐ **Yes** ☐ **No**

Comments: _____

_____

_____

Practitioner's name: _____ Practitioner type: _____

Provider number: _____

Address: _____

_____

Email: _____ Phone number: ( ) _____

I declare that the information I am providing is true and correct and any opinion above is my true opinion.

Signature: _____ Date: _____

Completing and submitting this form

To assist us to determine whether your injury was caused by an accident, we need you or your parent/guardian to complete all sections of this form. The completion of this form is a requirement of ahm's Fund Rules.

Once all sections of the form are complete and signed log in to your account at **ahm.com.au**, go to the **Upload documents** section and upload this form under the **Accident claim form** option.

You can also email the form to **ahmclinical@ahm.com.au** or post to us at **ahm health insurance Locked Bag 4, Wetherill Park NSW 2164**.

Please note that a hospital may submit the form on your behalf.

What happens next?

Once we have received the completed Accident claim form, we will determine whether the condition for which you require hospital treatment is the result of an accident for the purposes of ahm's Fund Rules. This can take up to 10 working days.

Once a determination has been made, we will notify you or your Parent/Guardian using your preferred contact method (unless requested otherwise). We may also notify the healthcare providers involved in your treatment.

ahm's privacy statement

ahm collects and uses personal information from this form, and more generally as part of the accident assessment process, to determine whether the condition for which you require hospital treatment is the result of an accident and to confirm whether you are eligible for payment of any benefits towards the costs of your hospital treatment. We also collect and use this information to determine whether your claim may be subject to compensation. If we do not collect this information, we may not be able to determine your eligibility for benefits. We may disclose personal information to persons or organisations in Australia and overseas including other Medibank Group Companies and our service providers, professional advisers, suppliers and partners. We may also disclose information to your healthcare providers, other persons covered under your policy or your agents, solicitors, insurers and advisers.

Our Privacy Policy contains more information about our privacy practices, including how you may request access to, or correction of, personal information, how to lodge a privacy complaint and how we manage such complaints. You can obtain a copy of our Privacy Policy at **ahm.com.au**

If you have any questions or need help, message us at **ahm.com.au** - weekdays 8am - 7pm (AEST/AEDT).

*See the Member Guide for how we define an 'accident'.