Claim

ahm health insurance

1 Your details Please use black pen and print in UPPER CASE.

Member number | Title | Firstname(s)

Surname | Date of birth (D D M M Y Y)

2 Hospital service details Please complete this section if any of the services were performed while you were an inpatient in hospital.

Name of hospital | Date of admission (D D M M Y Y)

Nature of illness | Date of discharge (D D M M Y Y)

3 Statement by member Do you intend to make a claim for payment of these services from another party or insurer regarding worker's compensation, motor vehicle accident, school injury, medical negligence, public liability or any other form of compensation?

☐ **NO** ☐ **YES** If YES, please give details:

Were you travelling to or from work? ☐ **NO** ☐ **YES**

4 Details of claim Your original account/receipts/Medicare statement of benefits must accompany this claim. **These will not be returned to you.**

	Provider paid Y/N	Patient code*	Patient's first name	Date of service (D D M M Y Y)
1				
2				
3				
4				

* This is the number shown next to the patient's name on the member card

	Provider name	Provider number	Type of service
1			
2			
3			
4			

Type of service Please write the appropriate code in the box.
1 Chiropractic
2 Physiotherapy
3 Podiatry
4 Acupuncture
5 Naturopathy
6 Osteopathy
For other claim types, please write the name eg. Dental, Optical etc

Note: For certain claims, like sight correcting appliances, Medicare Gap, pharmaceutical, orthodontics, travel and accommodation we may need more information than is on your receipt. Please check the Member Guide or contact us for what you need.

5 Declaration by member I declare that the information on this form is true and correct. I authorise ahm to check any of these services with the relevant provider and if any benefits have already been paid. I acknowledge that ahm health insurance may use the information on this claim form to assess and process this claim, or for other purposes related to this claim as outlined in the ahm Privacy Policy. I confirm the services submitted on this claim form were performed by the providers, and received by the persons named on this form. I declare these services cannot be claimed from any other source unless specified in question 3 above.

Member's signature

Date: / /

Submitting your claim

Email this form and a copy of your receipts to **info@ahm.com.au** with your **ahm member number** and **'Claim form'** in the email subject.

You can also post to ahm health insurance Locked Bag 4, Wetherill Park NSW 2164

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