CLAIM FORM

STEP 1 Complete your policy details

Policy Number | | | | | | | | |

Medicare number (if applicable) | | | | | | | | | | | |

Your family name. . . . . Your first name. . . . . .

Your current postal address (this is the address we will send any correspondence to do with this claim)

. . . . . .

State. . . . . Postcode. . . . . .

Phone number. . . . . Mobile. . . . . .

STEP 2 Complete the details of your claim

I am claiming medical services received in a hospital (e.g. Doctor and Specialist fees)

Date of admission	Date of discharge	Name of the hospital	Is this related to compensation?	Is this the result of an accident?
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐

I am claiming everyday Extras (e.g. General dental, Optical, Physiotherapy)

Date	Type of service	Name of the provider	Is this related to compensation?	Is the account paid in full?
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐

STEP 3 How do you want IMAN to pay your claim?

☐ Please credit my SafeClaim account (if you have authorised IMAN to credit your account using a Direct Credit Authority Form)

☐ Please send me a cheque made out in my name

☐ Please send me a cheque made out in my partner's name (only available if you have authorised IMAN to do this)

If you have not yet paid the account, IMAN will send you a cheque to forward to your provider. You will need to pay the rest of your bill.

Please note: Claim benefits are paid by nib health funds limited abn 83 000 124 381 (on behalf of IMAN Australian Health Plans Pty Ltd ABN 34 144 907 746).

STEP 4 Please answer the below questions

1. Is any part of your IMAN health premium either reimbursed or directly paid for by your Sponsor/Employer? **Yes** ☐ **No** ☐
   If you answered Yes to question 1 above please skip question 2.
2. Do you have an Australian Business Number (ABN), and are you registered for Goods and Services Tax (GST)? **Yes** ☐ **No** ☐

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IMAN Australian Health Plans Pty Ltd ABN 34 144 907 746
a subsidiary of nib holdings limited ABN 51 125 633 856

STEP 5 Read the following important information and sign this form

By signing this form, I declare that all information I have provided to IMAN, including all information in this form, is true & correct. I authorise IMAN to use this information and any other information I have previously given IMAN to assess and process my claim(s). I consent to IMAN contacting my previous health fund and/or service provider to request information and/or personal and medical records to verify any aspect of the claim(s). I acknowledge and provide consent for IMAN to use this information for other purposes related to this claim as outlined in the IMAN Privacy Policy.

I confirm these services have not been claimed as Point of Service such as HICAPS and that this claim is not subject to workers compensation, damages action, third party insurance or any other source.

I confirm that the services I am claiming were performed by the providers, and received by the persons as indicated on the healthcare provider's receipts.

Your Signature. . . . . Date ____ /____ /_____
(or your authorised partner)

CLAIMS CHECKLIST

- ☐ I have attached all the receipts and/or accounts for each item I am claiming.
- ☐ All the receipts/accounts I have attached are original, itemised in full, written in English, and are on the provider's official stationery or have the provider's official stamp.
- ☐ I received the services within the last two years. (IMAN does not pay claims made two years or more after the services were received)
- ☐ I am claiming services from an IMAN recognised provider. (IMAN does not pay claims for the services of providers who are not recognised by IMAN)
- ☐ I have claimed with Medicare for medical services I had in hospital and I have attached the top portion of the Medicare Statement of Benefits and my receipts.
- ☐ I have indicated where applicable that the claim is related to worker's compensation.

TO SUBMIT YOUR FORM

Complete your form and submit in one of the following ways:

Mail
IMAN Australian Health Plans
Reply Paid 62208
Locked Bag 2010
Newcastle NSW 2300

Email
info@austhealth.com

Fax
+61 2 9929 3818

If you have questions call the Customer Care Centre:

Monday to Friday 8.30am – 6.00pm (AEDT)

Call **1800 22 11 33**

From overseas **+61 2 4914 1131**

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