Travel Expenses Claim Form

- Travel expenses benefit is for the patient only for medical services not available in the member's residential area, and must be referred by a Medicare registered practicioner.
- Travel expenses benefit will only be paid for a referred specialist consultation, essential follow up medical or out-patient hospital treatment where the sole reason for travel was for these services.
- Journey must be over 200km return from the member's home locality to the locality of the treatment, as shown through Westfund travel benefit calculator.
- A copy of the account or receipt MUST be submitted together with the Travel Expenses Claim Form.
- If no account or receipt is available, the Doctor's signature AND surgery stamp MUST be obtained.
- A travel expense will only be paid if a Medicare Item Number applies for the services.

We're here for you

Member

Membership Number: _____

Member's Full Name: _____

Patient

Patient's Name: _____
First/Middle/Surname

Patient's Address: _____ P/Code: _____

Provider

Doctor's Name: _____ Date of Attendance: ____/____/____ (Day Month Year)

Address of Surgery attended: _____ P /Code: _____

Referring Doctor: _____

Is a copy of receipt or account attached? Yes ☐ No ☐

(If no account or receipt attached, the treating Doctors signature and Surgery Stamp must be obtained.)

Signature of Treating Doctor (or practice administrator):

.....

Surgery Stamp

Authority for Payment

EFT Details

Would you like your refund deposited into your bank account? Yes ☐ No ☐

Name of Financial Institution: _____

Account Name: _____

BSB ☐☐☐☐☐☐ Account Number ☐☐☐☐☐☐☐☐☐

Email Address: _____

Agent Details

*** Only complete this section if authorising another person to collect cash on your behalf. Your agent will be asked to provide satisfactory personal identification.**

Agent's Name: _____

Agent's Address: _____ P/Code: _____

Agent's Signature: _____ Date: ____/____/____ (Day Month Year)

Member's Signature:..... Date: ____/____/____ (Day Month Year)

Declaration

I declare that this claim is for treatment received by myself and/or dependants. All details and answers in this form and all attached documents are true and correct.
I authorise my medical practitioner, or health services provider, to provide Westfund with any details of medical treatment, hospitalisation, injury, disease, ailment or diagnosis about me or my dependants necessary to assess my entitlements.

(a) Is this claim the result of an accident?_____ Yes ☐ No ☐

(b) Are you eligible to recover any costs/damages from any other source?
eg. Third Party, Workers Comp, etc. _____ Yes ☐ No ☐

(c) Were you a hospital in-patient? _____ Yes ☐ No ☐

Signature of Member: ..... Date: ____/____/____ (Day Month Year)

OFFICE USE ONLY

Is the account/receipt attached or surgery stamp and signature verified? Yes ☐ No ☐

TravelMate: _____ (kms)

Verified by: _____

Date: ____/____/____ (Day Month Year)

Benefit Paid: _____

Payee: _____

Claim Number: _____

Cheque Number: _____

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