

Travel Benefit Claim Form

- Travel benefit is for the patient only for medical services not available in the member's residential area, and must be referred by a general practitioner.
- Travel benefit may be paid for a referred Specialist consultation, essential follow up medical or out-patient hospital treatment.
- Journey must be over 200km return from the member's home locality to the locality of the treatment. As shown on www.travelmate.com.au (map maker/how far?).
- A copy of the account or receipt must be submitted together with the Travel form. If no account or receipt is available, the Doctor's signature and surgery stamp must be obtained.
- Limit of one claim per membership per journey.

Member	Membership Number: _____
	Member's Full Name: _____ <small style="text-align: center;">First / Middle / Surname</small>

Patient	Patient's Name: _____ <small style="text-align: center;">First / Middle / Surname</small>
	Patient's Address: _____ P/Code: _____

Provider	Doctors Name: _____ Date of Attendance: _____ / _____ / _____ <small style="text-align: center;">Day Month Year</small>
	Address of Surgery attended: _____ P/Code: _____
	Referring Doctor: _____
	Is copy of Receipt or Account attached? Yes <input type="checkbox"/> No <input type="checkbox"/> (If no account or receipt is attached, the treating Doctors signature and Surgery Stamp must be obtained.)
	Signature of Treating Doctor (or practice administrator): _____
	Surgery Stamp

Authority for Payment

EFT Transfer Details	Would you like your refund deposited directly into your bank account? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Name of Financial Institution: _____
	Account Name: _____
	BSB <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Account Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	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: _____	P/Code: _____
	Agent's Address: _____	P/Code: _____
	Agent's Signature: _____	Date: _____ / _____ / _____ <small style="text-align: center;">Day Month Year</small>
	Member's Signature: _____	Date: _____ / _____ / _____ <small style="text-align: center;">Day Month Year</small>

Declaration

INFORMATION AUTHORITY AND WARRANTY

I, hereby authorise any hospital, medical practioner or any other person who has attended me (or my dependant), including any employer or accountant, to furnish to Westfund Ltd, or it's representatives within:

(i) All copies of hospital and medical reports/notes pertaining to this claim,
 (ii) All copies of my employment records pertaining to this claim and
 (iii) All information pertaining to my medical history, including any sickness, disease or injury, consultation, prescription or treatment, pertaining to this claim.

I understand and agree that a photocopy of this authorisation shall be considered effective and valid as the original and I specifically authorise it's use as such.

I declare that the particulars outlined by me (or dependant) in this claim are true and correct in every detail and I acknowledge that Westfund Ltd relies upon the truthfulness of the particulars supplied by me in respect of this claim.

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	Travel Mate: _____ (kms) <small>(from locality to locality)</small>	Benefit Paid: _____
	Verified by: _____	Payee: _____
	Date: _____ / _____ / _____ <small style="text-align: center;">Day Month Year</small>	Claim Number: _____
		Cheque Number: _____



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