WESTFUND
NOW I FEEL SECURE
Healthcover for the country

# CLAIM FORM

Westfund Home Office
PO Box 235, Railway Pde Lithgow NSW 2790
Phone: 1300 552 132 Fax: (02) 6352 3080 Email: enquiries@westfund.com.au

## 1. Member Details

USE BLOCK LETTERS

MEMBERSHIP NUMBER

MEMBER'S SURNAME

FIRST AND MIDDLE NAME

ADDRESS

POST CODE

HOME PHONE ( )

WORK PHONE ( )

## 2. Claim Information

| Patient First Name | Date of Birth D.M.Y | Practitioner Name | Date of Service D.M.Y | Has account been paid? Y / N |
|---|---|---|---|---|
| .................... | __ / __ / __ | .......................... | __ / __ / __ | ____ ____ |
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IMPORTANT INFORMATION
Please attach all original or certified duplicate accounts/receipts to the claim form.
*Photocopies will not be accepted. Accounts should be unaltered.*
Claims must be made within 2 years of date of service to be eligible for a benefit.

## 3. Questions

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 inpatient? YES ☐ NO ☐

*If YES, period of hospitalisation from* ___ / ___ / ___ to ___ / ___ / ___

Name of Hospital ........................................................................................................

## 4. Electronic Funds Transfer Details

a) Would you like your benefit deposited directly into your bank account? YES ☐ NO ☐
If YES, go to (b)

b) Do you wish to nominate a bank account other than that stated on your membership application? YES ☐ NO ☐
If YES, go to (c)

c) BANK DETAILS

NAME OF FINANCIAL INSTITUTION

ACCOUNT NAME

BSB

ACCOUNT NUMBER

These changes will apply to **this claim only**. For permanent change to your direct credit details, please complete a Westfund Application/Change of details form.

## 5. Signature and Declaration

I declare that this claim is for treatment or services received by myself and/or dependants. All details and answers in this form and all attached documents are true and correct. I authorise any medical practitioner, or other health service 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.

MEMBER'S SIGNATURE

DATE / /

## 6. Agents Authority

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:

ADDRESS:

POST CODE

MEMBER'S SIGNATURE

AGENT'S SIGNATURE

DATE / /

**OFFICE USE ONLY**

**VERIFIED BY:**

**CLAIM No.:**

**BENEFIT PAID:**

**CHEQUE No.:**

**PAYEE:**

**DATE:** / /

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All information provided by you to Westfund is treated with the utmost confidentiality and will only be used to provide you with the products and services you request. Your personal details will not be disclosed to third parties without your approval.

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