CLAIM FORM

Updated April 2017

TEACHERS HEALTH

CHECKLIST

- I have provided my membership number
- I have signed the declaration
- I have attached relevant original itemised receipts and accounts
- If I am claiming for orthodontia, aids and appliances, travel or contraceptive medication, and/or healthy lifestyle benefits, I have provided the additional documentation required (visit teachershealth.com.au for more information)
- If I am claiming for medical services received as an inpatient in hospital, and have already claimed from Medicare, I have attached the top section of the Medicare statement without the cheque or the Medicare Statement of Benefits.

WHAT YOU NEED TO KNOW

Accounts and receipts must be original and include the following:

- The service provider's/supplier's full details on official stationery
- The full name and address of the recipient of the services
- The item number and/or description of the services
- The date of each service
- The cost of each service, the amount paid and balance owing

Benefits will be paid into the account listed on your membership.

Check your account details in Online Member Services at **teachershealth.com.au** or call **1300 728 188**.

Benefits for goods/services not yet paid for will be via a cheque made out to the provider and posted to your postal address. Claims must be made within two years of the date of service.

SUBMITTING YOUR CLAIM

You can submit your claim form, receipts and relevant documentation by:

Member app	**Download at teachershealth.com.au/app**
Email	**submitclaim@teachershealth.com.au**
Mail	**GPO Box 9812, Sydney NSW 2001**

Find out more about claiming at teachershealth.com.au

A. YOUR DETAILS

Member number | | | | | | | | | Title ◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Dr

Given names | | Surname | |

Address (including suburb): (If your contact information has changed since your last claim, please complete the section below)

	State		Postcode	

Postal address (including suburb) if different to above address

	State		Postcode	

Home phone | | Mobile | |

Email | |

B. CLAIM DETAILS

FIRST NAME	DATE OF BIRTH	SERVICE TYPE	PROVIDER / DOCTOR	SERVICE DATE	SERVICE COST	ACCOUNT PAID
	/ /					◯ Yes ◯ No
	/ /					◯ Yes ◯ No
	/ /					◯ Yes ◯ No
	/ /					◯ Yes ◯ No
	/ /					◯ Yes ◯ No
	/ /					◯ Yes ◯ No
	/ /					◯ Yes ◯ No
	/ /					◯ Yes ◯ No

Please note: Benefits will be paid into the account listed on your membership.
Benefits for 21–25 year old student dependants can only be paid when they are registered with the Fund. You can update these details at teachershealth.com.au

C. IN-HOSPITAL MEDICAL CLAIM

Were any of the services performed whilst the patient was in hospital or same–day surgery? ◯ No ◯ Yes (if yes, please provide details)

Name of hospital | |

Admission date D D / M M / Y Y Y Y Discharge date D D / M M / Y Y Y Y

Adding a newborn baby? ◯ Daughter ◯ Son DOB D D / M M / Y Y Y Y

Full name | |

D. DECLARATION

Is there any entitlement for Workers Compensation, Third Party Insurance or other damages? ◯ **Yes** ◯ **No**

I declare that: I have incurred the expenses for these services. To the best of my knowledge, all the information in this claim is true and correct. I hereby authorise contact with the referring practitioner or the provider of the services if clarification of the details on the accounts/receipts is required for assessment purposes.

Signature

Date D D / M M / Y Y Y Y

WHAT NEXT? Once form is completed please attach receipts and send to **GPO Box 9812, Sydney NSW 2001** or **submitclaim@teachershealth.com.au**