

CLAIM FORM

Updated June 2023

HOW TO CLAIM

1. Complete this form

Ensuring you have:

- Provided your **membership number**
- Signed the **declaration**.

2. Attach supporting documents

Extras claims (see below for info on these requirements)

- Itemised **receipt(s)**
- Additional **form** or **letter** (if required).

Hospital claims (inpatient services)

First, claim Hospital or Medical (Specialist) bills from **Medicare** (via a [two-way claim form](#)). Then:

- Do attach your **Medicare Statement of Benefit**
- Don't attach your cheque, Statement of Claim & Benefit Payment or Medicare Claims History.

3. Submit your claim

Send your complete claim form, and any other relevant documentation, to us via:

- **App:** if you're not already using the member app, visit teachershealth.com.au/app
- **Email:** submitclaim@teachershealth.com.au
- **Post:** GPO Box 9812, Sydney NSW 2001

4. Receive your benefit!

Claims are paid into your nominated bank account. You can add, or change, your direct credit account detail via Online Member Services anytime.

For a step-by-step guide to [updating your direct credit account](#) visit teachershealth.com.au/direct-credit

For more on claiming for Extras and Hospital services, go to teachershealth.com.au/claiming

ITEMISED RECEIPTS

Please ensure all receipts include the **provider's**:

- **Official letterhead** or stamp
- **Name**
- **Address** the service was provided
- **Phone number**
- **Provider number** (if available) and/or provider's registration number with professional associations
- **Signature** (or their representative's).

Receipts must also be **itemised** with:

- **Patient name**
- **Date, type** and **cost** of each individual service
- **Body part identifier, prescription/script number** or **tooth ID** (where required)
- Whether the bill has been **paid**.

Lastly:

- We don't need original receipts – clear copies are fine
- We can't accept receipts with handwritten provider details or alterations to the costs.

ADDITIONAL FORMS/LETTERS

You may have to submit additional documentation to claim for these Extras services:

- **Aids and appliances** – some claims require an [Aids and Appliances Form](#)
- **Contraceptive medication** – see if you can claim under the [Pharmaceutical benefit](#)
- **Healthy Lifestyle** – some claims require a [Healthy Lifestyle Program Form](#)
- **Travel** – check the requirements for [travel claims](#)

A. YOUR DETAILS

Member number

Title Mr Mrs Miss Ms Dr

First name

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	BILL PAID
	/ /					<input type="radio"/> Yes <input type="radio"/> No
	/ /					<input type="radio"/> Yes <input type="radio"/> No
	/ /					<input type="radio"/> Yes <input type="radio"/> No
	/ /					<input type="radio"/> Yes <input type="radio"/> No
	/ /					<input type="radio"/> Yes <input type="radio"/> No
	/ /					<input type="radio"/> Yes <input type="radio"/> No
	/ /					<input type="radio"/> Yes <input type="radio"/> No
	/ /					<input type="radio"/> Yes <input type="radio"/> No

Note: Benefits will be paid into the bank account listed on your membership. Benefits for 21–31 year old student dependants can only be paid if they are registered (as a student dependant) on your membership. To update these details go to teachershealth.com.au/register-dependant

C. IN-HOSPITAL MEDICAL CLAIMS

If any of the services listed above were received while the patient was admitted to hospital/same-day surgery, complete this section.

Name of hospital

Admission date

Discharge date

Adding a newborn baby?

Full name

Daughter Son DOB

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 receipts are required for assessment purposes. The submitted receipts are true copies of the originals.

Signature

Date

WHAT NEXT? Send your completed form and receipts to GPO Box 9812, Sydney NSW 2001 or submitclaim@teachershealth.com.au

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