Extras and In-Patient Medical Claim Form

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doctors health fund
an Avant company

Make this claim the easy way

Instead of completing this form, claim using our smartphone app.
To download the app visit the iTunes App store or Google Play store and search for "Doctors' Health Fund".

Important information to note

All extras and in-patient medical claims will now be **paid directly to you**, whether or not you have paid the invoice.

1. **Making a claim:**
   - If you don't have a smartphone use this form to claim for extras or in-patient medical services.
   - Please contact us if you have a claim for outpatient medical services or invoices from a hospital facility.
   - If you need to update your details please do so through your Online Member Services, prior to making a claim.
   - Send this completed claim form, and the invoices/receipts for the claimed services, to the email or postal address above.
2. **Our payment of a claim:**
   - We will assess your claim according to our Fund Rules and the Terms and Conditions of claiming.
   - We will make our payment into your nominated bank account or by cheque.
3. **Checking a claim:**
   - Summaries of our payments to you are available in your Online Member Services.

Membership number _____ Given Names _____

Surname _____ Preferred contact number for this claim _____

Person making this claim _____ (where different to that above)

Attach the accounts and receipts for the treatments you list below, please make one entry per account or receipt.

Patient's Name	Name of provider

For in-patient medical services: Admission date DD / MM / YYYY Discharge date DD / MM / YYYY

Hospital name _____

I declare; all information provided in support of this claim is true and complete, all patients' personal information has been disclosed with their consent, and all patients are aware of the Doctors' Health Fund Privacy Policy. I authorise, and have the consent of the patient to authorise, Doctors' Health Fund to contact provider(s) and to access any information, including health information, needed to process this claim. I acknowledge that this claim is subject to Doctors' Health Fund's Fund Rules and will comply with any reasonable requests made under those rules.

Signature ✗ _____ Date DD / MM / YYYY

Terms and conditions of claiming, which govern this claim, can be viewed on our website.

Effective date: 1 July 2015