Health benefits claim form

Member details

Accounts/receipts must be included. Please do not staple or tape to claim form.

Member number

Title or rank	**First name**	**Last name**
Home address	**Suburb**	**State** / **Postcode**
Mobile phone	**Email address**	

1. Patient(s) detail

Full name	**Date of birth**	**Date of service**	**Type of service**	**Name of provider** (include practice suburb)
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		

2. Payment to bank account

I authorise Defence Health to:

○ Pay my benefit into my previously registered account ○ Pay my benefit for this and all future claims into the account nominated below.

Name and branch of financial institution | **Account holder name**

BSB number – **Account number**

It is your responsibility to settle any balance with the provider.

3. Claimable from another source

a) Are any of the services related to an accident, injury or condition which has, or may, result in compensation or damages from another source (e.g. work, transport accident, etc.)? **If Yes please complete the Accident questionnaire overleaf.** ○ Yes ○ No

b) Can any of the services be subsidised or claimed from another source (e.g. DVA, Child Dental Benefits Schedule)? **If Yes please provide details.** ○ Yes ○ No

Declaration

I declare that:

- I have incurred the expenses in this claim and the information supplied is true and correct.
- I have read the Defence Health Privacy Policy (which I have a copy of or which I can view at defencehealth.com.au or request by calling **1800 335 425**). I have informed my dependants about the Privacy Policy. I consent to the use, disclosure and handling of my personal information and that of my dependants in accordance with that Policy.
- I have obtained the consent of any dependant aged 16 and over to provide the sensitive information required to claim.
- I have informed my dependants who are 16 years and over that they may apply to Defence Health to restrict other policy members from accessing their personal information.
- I authorise Defence Health to obtain such information as is necessary from the provider to verify or audit this claim.

Signature

Date / /

The Defence Health Privacy Policy can be viewed on our website or call us to have it posted to you. Submit your claim via the methods below:

P 1800 335 425
E claims@defencehealth.com.au
defencehealth.com.au

PO Box 7518
Melbourne, Victoria 3004
Defence Health Limited
ABN 80 008 629 481 | AFSL 313890

DEF0638/07-26

Defence Health
We look after our own.

Accident questionnaire

Claim details (please print)

Some accidents, injuries, or conditions can be claimed from another source. Please complete the following questions about the nature of your claim.

Member number

Please remember to sign and date this form!

Name of patient

Date of accident / injury, or when condition first occurred / /

Nature of injury or condition

Place where accident or injury occurred

State

Describe how the accident, injury or condition occurred

Name of registered practitioner who first provided treatment

Practice or hospital address

Suburb | **State** | **Postcode** | **Practice or hospital phone number**

Please attach evidence from your registered practitioner that you sought treatment within 72 hours of the accident occurring.

Date of hospital admission (or proposed admission) resulting from the accident/injury / / to / /

Is there any eligibility to claim for compensation in respect to this accident, injury or condition? ○ Yes ○ No

Name and address of solicitor or any other party acting in connection with such a claim

Name and address of insurance company involved

Is there any entitlement to claim through DVA in respect to this accident, injury or condition? ○ Yes ○ No

If yes, DVA Card No and please attach a list of accepted conditions

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Accident questionnaire

Workers compensation

Did the accident, injury or condition happen at work or going to or from work? ○ Yes ○ No

Have you lodged a claim with your employer or workers compensation? ○ Yes ○ No

If you are not entitled to compensation, please state reasons. Further clarification may be sought.

What is your occupation?

Are you self employed? ○ Yes ○ No

Transport accident

Did the accident, injury or condition occur when travelling in a motor vehicle or on public transport? ○ Yes ○ No

Was another vehicle involved? ○ Yes ○ No

Were you: ○ Driver ○ Passenger ○ Other

Have you lodged a claim with the Transport Accident Commission (Vic) or third party insurance? ○ Yes ○ No

If you are not entitled to compensation, please state reasons. Further clarification may be sought.

Crimes compensation

Is your injury or condition the result of negligence or violence by another person? ○ Yes ○ No

Have you lodged a claim for criminal injuries compensation? ○ Yes ○ No

Do you intend to pursue a common law personal injuries claim? ○ Yes ○ No

Settlement details

Have you received a common law, third party or workers compensation settlement for this accident, injury or condition? ○ Yes ○ No

If yes, please attach a copy of the Award or Settlement.

Declaration

I authorise Defence Health Ltd ABN 80 008 629 481 to contact the necessary people if additional information is required to establish my eligibility for benefits. I declare that the information given is true and correct.

Signature

Date / /

Note: Defence Health reserves the right to seek further supporting documentation as necessary prior to assessing benefits.

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