



Claim Form

Tips for making a claim

- Complete the claim form and attach your accounts and receipts. Scanned, faxed and photocopies are acceptable.
- All accounts are retained by GMF Health and can not be returned. Please keep a copy of accounts and receipts for your records.
- If you have claimed from Medicare for in-hospital medical services please include the Medicare Statement of Benefit.
- A benefit may not be paid unless the claim is lodged within the two years of the date of service.
- Ensure your membership is paid until at least the date of treatment.
- Please return your claim form and accounts to:
 - email: welcome@gmfhealth.com.au
 - fax: 1300 653 098 or
 - mail: PO Box 513, Kalgoorlie WA 6433.
- Over the counter cash claims are limited to \$500.
- Accounts must be unpaid or fully paid as GMF Health is unable to pay on part paid accounts.

1. Member Details

Membership Number

Title Given Name(s) Surname

Have the attached accounts been paid? All Some None (Please attach accounts and/or receipts)

Direct credit of benefits

Please complete this section if you would like your benefit credited directly to your financial institution. **Complete this section only if the details are new/different to those previously provided by you.** This authority will remain in force until it is changed or cancelled by the policy holder or partner. Account details must be those of policy holder or partner only.

Name of Financial Institution

BSB/Financial Institution Number

Account Number (credit card not accepted)

Account in the name of

Account Holder's Signature

2. Have your contact details changed?

Yes No If no please go to section 3

Postal Address

State

Postcode

Update this Address for all members current on the policy? Yes No

Daytime Phone Numbers (Enables GMF Health to minimise processing delays should any queries arise)

Home Phone

Work Phone

Mobile

Email Preferred Method of Contact Phone Email Mail

3. Is this claim resulting from an accident?

Yes No

Date of accident

If Yes, tick type of accident: Motor vehicle Home, school or sporting Whilst at work Other Please state below

4. If the treatment was in hospital, please complete this section.

Hospital Name

Date of Admission

Date of Discharge

Medicare Number

Card Ref

Expiry Date

IMPORTANT: All in-patient hospital accounts must be sent direct to GMF Health together with informed financial consent or quote from your Medical Practitioner. Gap Cover benefits will only be paid if the account has not been processed by Medicare.

5. Important declaration*

I certify that the service to which this claim relates has been received, that the information contained within the account is true and correct and authorise the provider of the service to provide to GMF Health all requested information, including clinical records relating to the service.

Signature (Policy holder/partner/permanent authority)

Date

Please print name

6. Authority to collect benefit*

Please complete if someone is collecting on your behalf.

I authorise the person whose signature I have witnessed here to collect cash/cheque due to me in respect of this claim.

Authorised Person's Signature

Authorised Person's Name (Please Print)



Privacy

GMF Health will use the information you supply on this form, and the information we collect from third parties in connection with your claim (see the declaration overleaf), to assess and process your claim. When you make the claim you consent to GMF Health collecting related sensitive information directly from those third parties or, if you are not the recipient of the treatment or service the subject of the claim, you give consent on behalf of that recipient. The Policyholder is responsible for maintaining the policy and paying premiums. So we will disclose information to them about benefit limits and treatment for all persons covered by the policy. We may also disclose to service providers contracted by us to offer you services in chronic disease management or health management.

The personal information we collect may be disclosed to our related companies. By making this claim you give your consent to us sharing the personal information we collect (including sensitive information) with related companies of GMF Health for the purpose of preventing and detecting fraudulent or invalid claims or misrepresentation, which would cause loss to the GMF Health.

We may also disclose certain personal information to your bank or financial institution if you choose to have your benefit paid by direct credit, and to any person you authorise to collect your benefit on your behalf.

GMF Health is also obliged by the Private Health Insurance Act 2007 to maintain certain transaction records and make those records available to the Department of Health and Ageing, the Private Health Insurance Ombudsman and Medicare Australia. We will disclose this and any other information as required by law.

If you do not provide personal information, which is required, or give the authority in the declaration overleaf, GMF Health may not be able to process your claim. In most circumstances you have a right to access any personal information, which we collect and hold about you. Please contact us if you wish to access your personal information. We may deny your request in some circumstances and if we do this, we will tell you why.

More information about the way we handle personal information is detailed in our Privacy Policy, which is available at gmfhealth.com.au or on request by calling a Member Service Consultant on 1300 653 099.