



# Claim Form



Health Insurance Fund of WA (HIF)  
ARBN 128 302 161  
An association incorporated in Western Australia  
A Registered Private Health Insurer

60 Stirling Street, PERTH WA 6000  
HIF, GPO Box X2221 PERTH WA 6847  
Phone: 1300 13 40 60 Fax: (08) 9328 3345  
E-mail: info@hif.com.au Web: www.hif.com.au

## Membership Details

Membership Number □ □ □ □ □ □ □ □	Title	First Names	Surname
Address		Suburb	State
			Postcode
Do you want all mail sent to the above address? Yes <input type="checkbox"/> No <input type="checkbox"/>		Phone Number	

## Ancillary Claim Details

Patients First Name	Provider of Service	Has the account been paid?	Did treatment result from Accident?

Ambulance Accounts: Do you hold a Pensioner Concession Card Yes  No

## Medical Claim Details (in-hospital accounts)

Name of Hospital	Date Admitted / /	Date Discharged / /
Medicare Number □ □ □ □ □ □ □ □ □ □	Medicare Card Reference Number □	Medicare Card Expiry Date /
Doctor(s) Name	At what stage did the doctor advise you in writing of the treatment cost?	
	Prior to treatment	After Treatment

I declare that:

- The doctor/s who rendered the service provided me with the treatment costs in writing as indicated above and I acknowledge this advice.
- The doctor's has/have informed me of any relevant financial interest regarding services or products provided or recommended to me.
- I authorise HIF to claim the Medicare rebate on my behalf and pay the benefit to the provider of the service.

Members signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Payment



**Claiming  
By Mail**

Select payment method  
(Cheque is default)

Cheque  Direct Credit

Direct Credit Details.

□ □ □ □ / □ □ □ □ | □ □ □ □ □ □ □ □ □ □ □ □ □ □  
BSB Account Number

Name of Account Holder: \_\_\_\_\_

Do you wish for all future claims to be paid into this account? Yes  No



**Claiming  
In Person**

Benefit  
= \$

Cash  Cheque

Signature: \_\_\_\_\_

Is someone claiming on your behalf? If yes, please fill in the details below:

Name of person claiming for you: \_\_\_\_\_

Signature: \_\_\_\_\_

Member's signature authorising payment  
to be given to person named above: \_\_\_\_\_

Please note that photo identification will be required when claiming on a members behalf

## Membership Changes

Please contact HIF on 1300 13 40 60 for queries and membership changes.

## Declaration

I declare that I have incurred the expenses to which this claim relates. None of the items claimed relate to an incident for which compensation or damages can or will be made. To the best of my knowledge and belief all information is true and correct.

I authorise HIF to contact the provider of any service if clarification of details is required.

Members signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Office Use Only.

Date Received. \_\_\_\_\_

Claim No. \_\_\_\_\_

DJT: \_\_\_\_\_

DPT: \_\_\_\_\_

Table: \_\_\_\_\_