

Please attach receipts

Send completed claims to:
GPO Box 9812
SYDNEY NSW 2001



Member Number:

Title: Given names: Surname:

✗ IF YOUR CONTACT INFORMATION HAS CHANGED SINCE YOUR LAST CLAIM, PLEASE COMPLETE THE SECTION BELOW:

Address (including suburb): State: Postcode:
Postal address (including suburb): State: Postcode:
Home phone: Daytime phone / Mobile:
Email:

A. Payment details – cheque or direct credit payment to your nominated account?

Cheque: If account details have not been submitted on a previous Claim Form, a cheque will be issued to the Primary Member.

Direct Credit: (Electronic deposit) If you have not previously supplied details for Direct Credit, please complete the financial details below and benefit payments will be transferred into the nominated account.

ACCOUNT DETAILS
Financial institution name:
Account name:
BSB no: -
Account number:

✗ PLEASE NOTE: MONEY WILL ONLY BE PAID INTO THE PRIMARY MEMBER'S ACCOUNT.

B. Claim details

First name patient	Date of birth	Type of service	Name of service provider/doctor	Date of service	Cost of service	Account paid
	/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No

Benefits for 21-25 year old student dependants can only be paid when registered with the fund.

Dependant registration

If a claim is being made for a Student Dependant (aged between 21 and 25) please complete

Is the Student Dependant studying full-time? Yes No
Was the student studying full-time at the date of the service? Yes No

Name of student	Age	Date of birth	School, College or University
		/ /	
		/ /	
		/ /	
		/ /	

C. In-hospital medical claim

Were any of the services performed whilst the patient was in hospital or same-day surgery? No Yes (if yes, please provide details)

Name of hospital: Admission date: Discharge date:

Adding a new born baby? Daughter Son Given names: DOB:

D. Declaration

Is there any entitlement for Workers Compensation, Third Party Insurance or other damages? No Yes

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 accounts/receipts is required for assessment purposes.

Primary member/Policy holder's signature:

Date:

Privacy: The Teachers Health Fund privacy policy can be viewed at www.teachershealth.com.au or contact us for a printed version.