GUHealth

Claim form

Complete your policy details

Health insurance policy number

Daytime phone number

Given name/s

Surname

Current postal address

Suburb

State

Postcode

Complete the details of your claim

I am claiming everyday Extras (e.g. ambulance, dental, optical, physio)

Date	Type of service	Name of the provider	Is this related to compensation?	Is the account paid in full?
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐

I am claiming medical services received in a hospital (e.g. doctors & specialists fees)

Date of admission	Date of discharge	Name of the hospital	Is this related to compensation?	Is this the result of an accident?
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐

How we will pay your claim

We will credit your direct credit account (if you have authorised GU Health to credit your account using a Direct Credit Authority form).

Read the following important information and sign this form

By signing this form, I declare that all information I have provided to GU Health, including all information in this form, is true & correct. I authorise GU Health to use this information and any other information I have previously given GU Health to assess and process my claim(s). I consent to GU Health contacting my previous health fund and/or service provider to request information and/or personal and medical records to verify any aspect of the claim(s). I acknowledge and provide consent for GU Health to use this information for other purposes related to this claim as outlined in the GU Health Privacy Policy.

I confirm these services have not been claimed at Point of Service such as iSOFT or HICAPS and that this claim is not subject to workers' compensation, damages action, third party insurance or any other source.

I confirm that the services I am claiming were performed by the providers, and received by the persons as indicated on the healthcare provider's receipts.

Signature Date

My claims checklist

- ☐ I have attached all the receipts and/or accounts for each item I am claiming.
- ☐ All the receipts/accounts I have attached are original, itemised in full, written in English, and are on the provider's official stationery or have the provider's official stamp.
- ☐ I received the services within the last two years. (We do not pay claims made two years or more after the services were received).
- ☐ I am claiming services from a provider recognised by the registered health insurer. (We do not pay claims for the services of providers who are not recognised by us).
- ☐ I have claimed with Medicare for medical services I had in hospital and I have attached the top portion of the Medicare Statement of Benefits and my receipts.
- ☐ I have indicated, where applicable, that the claim is related to workers' compensation.

Need help?

Visit **guhealth.com.au/contact-us**

Please return your completed form via

Online Services:
members.guhealth.com.au/Member/Account/Login

The GU Health app:
download the free GU Health App

Privacy

For information on how we manage your personal information, including how you can seek access to or correct your personal information, please refer to our privacy policy at **guhealth.com.au/privacy-policy**