rt health FUND (MEMBERS OWN HEALTH FUND)

I would like to make a *claim*

Your details

rt membership number

Given names

Family name

Date of birth (dd/mm/yy)

To update your contact details, please complete over the page.

What would you like to claim?

Date of purchase, service or treatment	Given name of the person who received the product, service or treatment	Name of the healthcare practitioner who provided the product, service or treatment	Has this account already been paid in full?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

How would you like your benefits to be paid? ☐ Into my nominated account ☐ By cheque

To update your bank account details, please complete over the page.

Is the condition for which benefits are being claimed one for which the patient has, or at any time had, a right to claim damages/ benefits from any other source, for example third party, workers compensation, repatriation, persons liable at law or school accident insurance? ☐ No ☐ Yes If yes, please attach details.

Declaration

I declare that all information on this form is true and correct. All products, services or treatments were received by the person named, and administered by the practitioner named. I authorise rt health fund (or its agent) to obtain information from the practitioner about any products, services or treatments claimed, or (in the case of new rt members) to contact my previous health fund.

Name of main member or authorised person

✗

Today's date

Send your completed form to us by:

- email: to help@rthealthfund.com.au
- fax: to 1300 887 123
- mail: to PO Box 545 Strawberry Hills NSW 2012
- or drop into one of our member care centres.

If you have any questions, our member care team is here to help. Call us on **1300 886 123.**

be well. get well. stay well.

Please remember

- If you have not paid the account, a cheque will be issued in the practitioner's name.
- All claims must be submitted within two years of the date of service.
- Please attach copies or original receipts for the products, services or treatments you are claiming. Remember to keep a copy for your records as we retain all originals.
- If you are claiming for gym memberships, health aids, orthotics, orthopaedic shoes or contraceptives, you will need to include a letter from your prescribing practitioner stating there is a medical reason for the purchase.
- For in hospital (inpatient) medical claims: if your account does not state that it is an Access Gap account, or advise you to send to your health fund first, please take your account to Medicare for processing first as we will need the Medicare statement to pay your claim (the original doctors' account is not required).
- Your health cover does not pay benefits for products, services or treatments purchased from or provided by practitioners overseas, whether you buy them in person, by mail or online.
- Benefits cannot be claimed for treatments or services provided by a healthcare practitioner who is either covered by the same membership or who contributes to the payment of the membership.

Complete this section to add/change the account claims benefits are paid into (this will permanently update your records)

Name of bank, building society or credit union

BSB number ☐☐☐–☐☐☐

Account number ☐☐☐☐☐☐☐☐☐

Account name

Two signatures are required if the account is not in the name of the main member or an authorised person.

Name of account holder

✗

Today's date

Name of main member

✗

Today's date

Only complete this section if we don't already have your current contact details

Home telephone number

Work telephone number

Mobile telephone number

Email address

Residential address

State

Postcode

Postal address (if different to your residential address)

State

Postcode