Health Management Claim Form

Under the Private Health Insurance Act 2007, Westfund is unable to pay General Treatment Benefits in relation to goods and services which are primarily for the purposes of sport, recreation or entertainment.
No benefits are payable where:
- The membership/class is not required for treatment of a specific condition or part of a health management program;
- The provider does not fulfil the recognised provider requirements;
- The health management program has not been referred by a Medicare registered practitioner;

Please attach all unaltered accounts/receipts. In the case of photocopies, faxes or emailed accounts/receipts original documents must be retained by you, the member, for a minimum of 24 months from the date the claim is made Westfund may request to sight the original document during this time. Claim must be made within two years of date of service to be eligible for benefit.

Please ensure all sections of this claim form have been completed before submitting the claim.

Claiming options:
- Email to claims@westfund.com.au
- Fax to (02) 6352 3408
- Post to:
  Westfund Home Office
  PO Box 235, Lithgow NSW 2790

Section A: to be completed by Member

Membership Number: _____

Member's Full name: _____
First/Middle/Surname

Member's Address: _____ P/Code: _____

Email Address: _____ Contact Phone Number: _____

Claim Information

Patient Full name: _____ Patient DOB: _____/_____/_____

Please note: for 'per class' services, individual fees and service dates need to be noted on receipt.

Health Management Program Provider	Date of Service:	Account Paid? Y / N

EFT Details

(a) Would you like your benefit deposited directly into your bank account? Yes ☐ No ☐ If YES, go to (b)

(b) Do you wish to nominate a bank account other than the account stated on your membership? Yes ☐ No ☐ If YES, go to (c)

(c) Do you wish to make this change permanently on your membership? Yes ☐ No ☐ If YES, go to (d)

(d) BANK DETAILS

NAME OF FINANCIAL INSTITUTION

ACCOUNT NAME

BSB ☐☐☐ ☐☐☐

ACCOUNT NUMBER

Questions

(a) Is this claim the result of an accident? Yes ☐ No ☐

(b) Are you eligible to recover any costs/damages from any other source, e.g. Third Party, Workers Comp etc? Yes ☐ No ☐

(c) Were you a hospital inpatient? Yes ☐ No ☐

If YES, period of hospitalisation from? _____/_____/_____ to _____/_____/_____

Name of hospital? _____

Signature and Declaration

I declare that this claim is for treatment or services received by myself and/or dependants. All details and answers in this form and all attached documents are true and correct. I authorise my medical practitioner, or health services provider, to provide Westfund with any details of medical treatment, hospitalisation, injury, disease, ailment or diagnosis about me or my dependants necessary to assess my entitlements. I have read and understood Westfund's Privacy Policy as referenced.

MEMBER'S SIGNATURE: DATE:

Section B: Referring Provider Details - must be completed by a Medicare Registered Practitioner

Profession: (please mark with a cross where appropriate)

- ☐ General Practitioner (GP)
- ☐ Medical Specialist
- ☐ Podiatrist
- ☐ Physiotherapist
- ☐ Psychologist
- ☐ Osteopath
- ☐ Chiropractor
- ☐ Occupational Therapist
- ☐ Exercise Physiologist
- ☐ Dietician

Provider Name: _____ Provider Number: _____

Contact Phone Number: _____

Patient Name: _____ Date of referral for health management program: _____/_____/_____

Health Condition

- ☐ Asthma
- ☐ Diabetes
- ☐ Mental Health Condition
- ☐ Musculoskeletal (orthopaedic) Condition
- ☐ Osteoporosis
- ☐ Obesity
- ☐ Cardiac Risk Factors (high blood pressure/cholesterol)
- ☐ Arthritis
- ☐ Rehabilitation
- ☐ Other (please specify) _____

Health Program Recommended

☐ Fitness Centre/Gym ☐ Pilates Centre ☐ Yoga ☐ Swimming for children under 18

I acknowledge my recommendation of the above service(s) to the above patient is valid for 12 months and forms part of a health management program that is intended to improve the specified health condition of the patient.

Signature: _____ Date: _____/_____/_____

Section C: Health Management Program Provider Details - to be completed by a Registered Provider/Member

Provider Details (please mark with a cross where appropriate)

- ☐ Fitness Centre/Gym (must be accredited with Fitness Australia)
- ☐ Pilates Centre (must be accredited with Australian Pilates Method Association)
- ☐ Yoga (must be accredited with Yoga Australia/International Yoga Teachers Association)
- ☐ Swimming for children under 18 (must be accredited with Swim Australia or AUSTSWIM/Australian Swimming Coaches & Teachers Association)

Name of Health Management Program Provider: _____

Association Membership Number: _____

OFFICE USE ONLY

Is receipt attached? ☐ Yes ☐ No

Is Section B completed on previous claim? ☐ Yes ☐ No Date of referral: _____/_____/_____

Note on membership? ☐ Yes

Verified by: _____

Date: _____/_____/_____

Benefit paid: _____

Payee: _____

Claim Number: _____

Cheque Number: _____

Westfund Ltd collects and uses your personal information such as your name, address, telephone and other contact details in order to answer your query or to provide our services to you. Westfund also collects sensitive information about you, such as your health information, in order to provide quotations for membership, to establish and maintain your policy and to provide health services to you. Unless it is unreasonable or impractical to do so, Westfund will collect your personal information from you. If you provide Westfund with the personal information of another person (such as about your family member), then you should make them aware of the matters contained in this notice. Not collecting your personal information would mean that Westfund would be unable to provide you with its services, taking into account matters such as government rebate entitlements, dependants, benefit entitlements and the settlement of your claims. Westfund may disclose your personal information to other entities. However, your personal information will only be disclosed to third parties where you would reasonably expect Westfund to in order to provide you with the services associated with your membership. This may include parties transacting business on behalf of Westfund and supporting Westfund's systems and services. Your personal information, including health information, may also be used if you access health services through Westfund's health, dental and optical divisions or to notify you of new products or promotions. Your personal information will not be disclosed to any overseas recipients. Westfund's Privacy Policy contains information about how you may access and seek correction of your personal information held by Westfund, and how you may make a complaint in relation to information privacy.Westfund's Privacy Policy is available at our website www.westfund.com.au and at any of Westfund's Care Centres. Further details can be obtained by contacting Westfund's Privacy Officer at privacy@westfund.com.au.