

Claim Form



Claiming Options:

Visit: Members Online Email to: claims@westfund.com.au Post to: Westfund, Po Box 235, Lithgow NSW 2790 or claim using our App

Please attach all unaltered accounts/receipts. In the case of photocopies and 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 and documents sent in are not returned. Claim must be made within two years of date of service to be eligible for a benefit. Benefits are payable at the date a service is provided. If all claim information is not supplied this may result in the claim/s not being paid.

Your Details

Member No:	Address:		
First Name:			
Surname:	City:		
Email:	Postcode:	State:	
Mobile:	Home:		

Patient and Claim Details

DOB:	First Name:	Date of Service:	Practitioner:

Electronic Transfer Details

Benefits will be paid into your nominated bank account, whether you submit a paid or unpaid account and you are responsible for paying the provider where an account has not yet been paid.

Do you wish to nominate a bank account other than the current bank account on your membership? If yes, please specify below:

a) Would you like to make this change permanently on your membership? Y N

OR

b) Do you wish to record these bank details against your name for future claims on this membership? Y N

BSB:	Account Number:
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Declaration and Statement

I understand that Extras benefits cannot be claimed from Westfund where they have been, or will be, claimed from Medicare (unless permitted by law).

If any part of this claim is the result of an accident, illness, injury, condition or other incident for which there exists in the opinion of Westfund, a right to claim compensation from a third party, or for which a payment or consideration in settlement of a claim for compensation or damages has been received, provide the date of event ____/____/____.

If any part of this claim was for services received while in a hospital as an inpatient, complete the following details:

Name of hospital: _____ Admitted: ___/___/___ Discharge date: ___/___/___

I declare that all information and documents provided in support of this claim are true and correct. I authorise my medical practitioner or other health service provider to provide Westfund with any information reasonably required to assess this claim, including details relating to treatment, hospitalisation, injury, disease, ailment or diagnosis for any person covered by this claim.

I consent to the collection, use and disclosure of personal information in accordance with Westfund's Privacy Policy. I confirm that I have read and understood this form and the conditions relating to this claim.

If I am completing or signing this form on behalf of another person, I confirm I have the authority to do so and have informed them of the privacy information and consents contained in this declaration.

Full Name:	Signature:	Date:
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Our Privacy Policy contains information about use and disclosure of personal information, how you may access and seek correction of your personal information, how you may make a complaint about privacy, and how we will respond to your complaint. Westfund's Privacy Policy is available on our website www.westfund.com.au and at any of our Care Centres.