Ambulance claim form

1. Please complete all the relevant sections of this form using **BLACK INK** and write within the boxes in **CAPITAL LETTERS**. Mark appropriate answer boxes with a **CROSS**. Start at the left of each answer space and leave a gap between words. **PLEASE DO NOT STAPLE**.
2. Claims must be submitted within 2 years from the date of service.
3. Read the declaration and sign all the relevant signature panels.

SECTION A: Your details

Membership number

Surname

First name

Initial Title

Date of birth D D M M Y Y

Sex (M/F)

Residential address

Postcode

Home Phone (including area code)

Work Phone (including area code)

Mobile

Email

SECTION B: Ambulance service details

Do you have a subscription with an ambulance service?

X Yes X No

Ambulance subscription number

Are you a Department of Social Security beneficiary (other than a Seniors Card holder)?

X Yes. If yes to the above question, please provide Pension number X No

Health Care card number

SECTION C: Transportation details

Date and time of ambulance transportation

D D M M Y Y : X AM X PM

Name and address of where journey commenced *(e.g. hospital name and address)*

Postcode

Name and address of destination *(e.g. hospital name and address)*

Postcode

Were you admitted to the above hospital?

X Yes X No

Purpose/reason for transportation *(i.e. medical condition or nature of medical treatment which necessitated ambulance transportation)*

If you were taken to hospital, how long were you there?

H H hours D D days W W week/s

Name of Medical Practitioner who treated you in hospital

Transport organised by *(e.g. yourself, doctor, relative etc)*

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Bupa HI Pty Ltd
ABN 81 000 057 590

SECTION D: Additional details

Please complete the following sections where applicable.

1. Are you entitled to compensation from any other source? X Yes X No
2. Did the need for Ambulance Transportation occur at work? X Yes X No
3. Did the need for Ambulance Transportation occur going to or from work? X Yes X No
4. Has a claim been lodged with your employer? X Yes X No
5. If no, do you intend to lodge a claim with your employer? X Yes X No
6. What is your occupation?

7. Are you self-employed? X Yes X No
8. Did the transport accident occur whilst travelling to or from work? X Yes X No
9. Do you intend to lodge a claim with the Transport Accident Commission or a Third Party Insurer? X Yes X No
10. Was the accident/injury the result of negligence or violence by another person? X Yes X No
11. Do you intend to lodge a claim against the Crimes Compensation Tribunal? X Yes X No
12. Do you intend to pursue a common law/personal injuries claim? X Yes X No

SECTION E: Complete bank details

Has this account been paid by you?

X Yes. If yes, please complete this section X No

Please ensure you have attached all invoices needed to process this claim. Are all the invoices attached to this form?

X Yes X No

Name(s) of account holder(s)

Name of financial institution

BSB number

Bank account number

If account details are not provides or authority is not present, benefit will be paid to the policyholder. Please enclose original account/receipt. All accounts/receipts and any documents supporting your claim will be retained by Bupa.

SECTION F: Please read then sign this declaration

I authorise Bupa to contact any necessary persons if information is required to establish my entitlement to benefits.

I declare that information provided on this form is true, correct and complete and will notify Bupa of any changes.

I declare that: my typed name stands as my signature for the purposes of this form.

Signature of Policyholder

Date D D M M Y Y Y Y

Just before you send

X Check that you have signed all the signature boxes relevant to your application, including the declaration above. **PLEASE DO NOT STAPLE.**

Please mail your claim form to:
Bupa Health Insurance GPO Box 4338 Melbourne VIC 3001

Alternatively, you can drop by a Bupa Health Insurance store. If you would like any assistance, please call us on **134 135**.
Bupa HI Pty Ltd ABN 81 000 057 590

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