Claim Form

Please complete all the relevant sections of the claim form using **BLACK INK** and write within the boxes with **CAPITAL LETTERS**. Mark all appropriate boxes with a **CROSS (X)**. All areas marked with an **ASTERISK (*)** must be completed.

Claims must be submitted within **2 years** from the date of service. If you are an **Overseas Student** or on **Overseas Visitors Cover** and are within **12 months** of your membership, and are claiming for a hospital or medical service other than a General Practitioner consultation, please attach a **Medical Certificate** with this Claim Form.

SECTION A: Your details

Bupa membership number

Surname

First name

Mobile

Email

Date of birth D D M M Y Y

Residential address

Postcode

Mail address *(if different from residential address)*

Postcode

SECTION B: Benefit payment

Name(s) of account holder(s)

Name of financial institution

BSB number –

Bank account number

If account details are not provided, the benefit will be paid to the policyholder.

Please enclose original accounts/receipts. Benefits for services provided by a hospital which you have paid in full will be reimbursed by cheque only. All accounts/receipts and any documents supporting your claim will be retained by Bupa.

We'll use these details and add them to your membership for future claims.

SECTION C: Orthodontics

Have you been paying for your orthodontic treatment in instalments? X Yes X No ▶ You are not required to fill in this section.

Is this your final claim: X Yes X No

If yes, what was your total cost of treatment?

SECTION D: Hospital and/or Compensation details (Please answer all applicable questions)

Were you treated as an inpatient in hospital?

X Yes ▶ Date of treatment: D D M M Y Y

X No

Reason for Treatment (Inpatient or Outpatient)

Was your illness/injury/condition caused or contributed to by someone else (such as in a transport or workplace accident/incident or by another person's negligent acts or omissions)?

X Yes X No

▼

Please provide details if a complaint or claim for compensation is to be made

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Bupa HI Pty Ltd
ABN 81 000 057 590

Declaration, acknowledgement and authority

Your Privacy is important to Bupa. We collect information from you for the purpose of assessing and administering your claim, and for related purposes outlined in the Bupa Information Handling Policy. We may also collect information about you from health service providers for the purposes of administering or verifying any claim. We may disclose your personal information to our related entities, and to third parties including healthcare providers, government and regulatory bodies, other private health insurers, and anyone engaged by us or acting on our behalf. If you do not provide all of the information we reasonably request, we may be unable to process your claim. Our Information Handling Policy contains information about how you can request access to and correction of personal information, how you can make a complaint about the handling of your personal information and how we otherwise handle your personal information. You can view the policy at bupa.com.au or by calling us on 134 135.

I declare that the services claimed were received by the patient and that all information on this form is true and correct.

I authorise Bupa to obtain information from the provider for any service claimed.

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

Applicant's signature

Date

D D M M Y Y Y Y

Just before you send

Please log into myBupa to submit your claim, or you can mail your 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**.

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