

MEMBERSHIP DETAILS		
Surname	First name and initials	Membership No.
.....		
Postal Address		
.....		Postcode
Phone: (Home)		(Work)
Is this your permanent address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PLEASE COMPLETE THE FOLLOWING QUESTIONS:		
(i)	Is this claim the result of an accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii)	Is there an entitlement to claim for workers compensation or third party insurance damage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iii)	Are you entitled to treatment under repatriation social services or any other benefit in respect to this claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No

CLAIM DETAILS			
Date of service	Patient's name	Provider's name	Account paid (YES/NO)
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.....
.....
.....
.....
.....
HAVE YOU ATTACHED THE RECEIPTS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please ensure where applicable, receipts are attached. Where only the account is supplied, the cheque will be made payable to the provider. Unless requested, all other refunds will be paid to your account. Failure to provide correct documentation could delay settlement of your claim.			
ADDING A NEW BORN CHILD			
Family name	First given name	2nd initial	Sex Date of birth
.....

DECLARATION	
I declare that the services claimed were received and that the above answers and particulars are true. I authorise practitioners named above to supply any information which will assist in processing this claim.	
Signed (by member)	Date

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