

Health Management Program Authorisation

Under CBHS Corporate Wellness Benefits, members can claim towards a health management program. The benefit is available to members if the health management program is **designed to improve or reduce a specific health or medical condition.**

Please submit this form along with your completed claim form and relevant receipts for the health management program.

SECTION 1 – Details of claimant

Member No. _____ Mr Mrs Miss Ms Dr
Claimant's Surname _____ D.O.B. D D / M M / Y Y Y Y
Claimant's Given name(s) _____

SECTION 2 – To be completed by your health practitioner (GP, Specialist, Physiotherapist or Allied Health service providers)

Practitioners Name _____ Provider Number _____
Phone Number () _____ Postcode _____

Please enter the patient's medical condition.

Please indicate the health management regime you are recommending to improve the patient's medical condition.

Gym membership

Personal Trainer

Please indicate the length of time you are recommending for this course of treatment _____ month/s.

Declaration (to be completed by the practitioner) I declare that the information I have provided is true and correct.

Practitioner's signature and practice stamp

Date signed

X

D D / M M / Y Y Y Y

SECTION 3 – Additional Information

Is this claim a result of an accident or trauma? Yes No

If 'Yes' please give the date / /

Is the claimant entitled to any form of compensation, damages or payment as a result of this accident or trauma?

Yes No If 'Yes' please provide brief details

Your GP's Name

Declaration of Authority, I declare that:

- the documents attached, supporting this claim, are for services rendered to myself or a dependant listed on my membership, and
- the information I have provided is true, complete and correct, and
- the claim is received as part of a health management program intended to improve or reduce a specific health condition(s).

I authorise CBHS Corporate Health Fund Limited to contact the provider of any service claimed and obtain any information relating to the claim.

Signature of Member (or Authorised Partner) _____ Date signed _____

X

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Privacy

How CBHS Corporate collects, uses and secures your personal information is described in the CBHS Corporate Privacy Policy.

CBHS Corporate Privacy Policy is available at cbhscorporatehealth.com.au or by calling 1300 586 462