CBHS CORPORATE

CBHS Corporate Health Pty Ltd ACN 85 609 980 896

Please send this claim form and any additional information:

**Paper claims email:** claims@cbhscorp.com.au
**Eclaims email:** eclaims@cbhscorp.com.au
**By post:** CBHS Corporate, Locked Bag 5098, Parramatta NSW 2124

# 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.

Claimant's Surname

Claimant's Given name(s)

Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Dr ◯

D.O.B. D D / M M / Y Y Y Y

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

Practitioner's Name

Phone Number ( ) 

Provider 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 practioner) **I declare that the information I have provided is true and correct.**

Practioner's signature and practice stamp

Date signed 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 D D / M M / Y Y Y Y

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

**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**