Queensland Country Health Fund

THERE'S A FASTER WAY TO CLAIM!

Download the Queensland Country Health Fund Mobile App today for an easy, convenient and secure way to manage your membership and claim quickly!

- **Submit a claim** Simply take a photo of your itemised account & receipt/s and press submit
- **Review your claims history**
- **View policy details including contribution details**
- **Check your annual benefit limits and see what's remaining**
- **Update your contact information**
- **Order new Membership Cards**

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Claim Form

YOUR DETAILS

Name _____ Membership Number _____

PAYMENT

I would like my claim to be paid:

- ☐ Into my existing account registered with Queensland Country Health Fund
- ☐ Into my new account

Account Holders Name _____ BSB _____ Account Number _____

COMMENTS

Let us know if there's anything special we should know about this claim. Things like you've changed your address or if you'd like to update your email address. If not, just leave blank.

All documentation will be retained by Queensland Country Health Fund. Please keep copies for your records. A claim for benefits must be submitted within two years of the date of service.

ACKNOWLEDGEMENT

- I declare that all of the information on this form is true and correct.
- I authorise Queensland Country Health Fund to use my personal information in accordance with the Privacy Policy. For more information about the Queensland Country Health Fund Privacy policy please refer to queenslandcountry.health/privacy or call **1800 813 415**.
- I further confirm that all persons to which this claim relates have provided their consent to such use and disclosure of their personal information.
- I confirm the services listed on this claim cannot be claimed from other sources including Medicare Australia, workers compensation, motor vehicle accident insurance or third party liability.

_____ _____

Sign here to agree to these conditions Date (dd/mm/yy)

Please send this form, itemised account & your receipt/s to:

Email: **info@queenslandcountry.health** **OR** Post: **PO Box 42 Aitkenvale QLD 4814**

Office Use Only

Claim Number _____ Processor _____