PROVIDER CLAIM FORM

Provider name:	
Provider number:	
Specialty type:	

☐ In-patient ☐ Out-patient ☐ Post Surgery Service

Member name:	
Member number:	
Patient name:	

Please attach all invoices to your claim form before returning to IMAN.

TO SUBMIT YOUR FORM

Complete your form and submit in one of the following ways:

Mail
IMAN Australian Health Plans
Reply Paid 62208
Locked Bag 2010
Newcastle NSW 2300

Email
info@austhealth.com

Fax
+61 2 9929 3818

If you have questions call the Customer Care Centre:
Monday to Friday 8.30am – 6.00pm (AEDT)

Call **1800 22 11 33**

From overseas **+61 2 4914 1131**

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IMAN Australian Health Plans Pty Ltd ABN 34 144 907 746
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