

# OSHC CLAIM FORM

## 1 Complete your policy details

Your customer number

Your surname \_\_\_\_\_ Your first name \_\_\_\_\_

Your current postal address (this is the address nib will send any correspondence to do with this claim)

\_\_\_\_\_ Daytime phone number ( ) \_\_\_\_\_

Do you have an Australian Business Number (ABN) and are you entitled to claim GST back on your policy premium?  Yes  No

If yes, what is your ABN?

## 2 Complete the details of your claim

### I am claiming everyday Extras (e.g. dental, optical, physio)

Date	Type of service	Name of the provider	Is this related to compensation?	Is the account paid in full?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

### I am claiming Medical services\* (e.g. doctors and specialist fees, prescriptions)

Date	Type of service	Name of the provider	Is this related to compensation?	Is this the result of an accident?	Is the account paid in full?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

\* Includes out-patient services

Is any claim related to services received while an in-patient in hospital?  Yes  No

If yes, which hospital? \_\_\_\_\_ The hospitalisation was from \_\_\_\_\_ to \_\_\_\_\_

Did you receive emergency ambulance transport?  Yes  No

Are the expenses claimed for a medical assessment, x-ray or blood test required for the renewal of your student visa?  Yes  No

**Need help completing this form?**

Call the nib Customer Care Centre on  
**1800 775 204** or email **niboshc@nib.com.au**

**nib**OSHC

### 3 Payment

Your benefits will be paid directly into your Direct Credit Authority account.

You may have set up a Direct Credit Authority account when you joined – if not, just download a Direct Credit Authority form from [nib.com.au/oshc](http://nib.com.au/oshc) or call us on **1800 775 204** and we can set one up for you.

### 4 Read the following important information and sign this form

Is any claim listed associated with an accident or injury for which a third party might be liable? This includes motor vehicle accidents, workers compensation, or injuries sustained where any other party may have been negligent e.g. public or occupiers liability.  Yes  No

If yes, date of accident \_\_\_\_\_

Type of injury or ailment \_\_\_\_\_

Describe how it occurred \_\_\_\_\_

I declare that all the information I have given on this form is true. I allow nib to use the information on this form and to use information I have previously given nib, and to contact if needed:

Yes  No  My previous fund.

Yes  No  My treating health professional/s and/or the provider of the services.

I acknowledge that nib may use the information on this claim form to assess and process this claim, or for other purposes related to this claim as outlined in the nib Privacy Policy. I authorise and consent to nib health funds passing on some or all of my claims information and other relevant policyholder information to a third party where necessary, and I acknowledge that this information may include the name and address of the provider, and a description of health services that I have received. I confirm the services submitted on this claim form were performed by the providers, and received by the persons named on this form. I declare the services above where I have indicated 'no' cannot be claimed from worker's compensation, a third party or any other source. I confirm these services have not been claims as Point of Service such as iSoft or HICAPS.

Your signature  
(or your authorised partner)

Date

### My claims checklist

- I have attached all the receipts and/or accounts for each item I am claiming.
- All the receipts/accounts I have attached are original, itemised in full, written in English, and are on the provider's official stationery or have the provider's official stamp.
- I received the services within the last two years.  
*(nib does not pay claims made two years or more after the services were received)*
- I have indicated where applicable that the claim is related to workers compensation or any other service claimable through another party or insurer.

**You can send  
your claims to  
this address  
(no stamp required)**

**nib Claims Processing**  
Reply Paid 62208  
Locked Bag 2010  
Newcastle NSW 2300