Ambulance Service Welfare Fund
13 Hindmarsh Place
HINDMARSH SA 5007
Phone: 08 8340 1800 **Fax:** 08 8340 1811
Email: info@aswf.net.au

CLAIM FORM - HEALTH INSURANCE EXCESS

A. CLAIMANTS DETAILS

FIRST NAME [ ] SURNAME [ ]

ADDRESS [ ] P/CODE [ ]

PHONE (H) [ ] (M) [ ] PAY NO. [ ]

B. PROVIDER DETAILS

HEALTH INSURANCE FUND [ ] MEMBERSHIP NO. [ ]

C. DETAILS OF HOSPITAL

NAME [ ] DATE OF ADMISSION [ ]

ADDRESS [ ]

D. PATIENT DETAILS

FIRST NAME [ ] SURNAME [ ]

E. REIMBURSEMENT DETAILS

A copy of the account from the hospital must be included with claim

☐ I have attached the paid invoice

F. PAYMENT DETAILS

ACCOUNT NAME [ ]

BSB/BANK [ ] ACCOUNT NO. [ ]

OFFICE USE ONLY:

Current ASWF Member
Current Medibank Member
No Previous Claims this calendar year
If previous claim – provide details Patient: ……………………………………… Claim Date: …………………………