Online claims form.

1. Member details

Any field marked by an asterisk (*) is mandatory and must be completed in all cases.
To move between fields, please use the TAB key.

Full name*

First name

Last name

Membership number

Address*

Email

Phone number

UniMed pays your claim reimbursement directly to your bank account, so...

- If you have already provided UniMed with your bank account details, select '**Use my current bank details**'.
- Or, if your bank account details have changed please select **'Add or Update my bank details'**.

My bank account details*

Use my current bank account details

Add or update my bank account details

Account number:

Name and date of birth of people for whom reimbursement is being claimed:*

	Name	Date of birth
1		
2		
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2. Details of all claims

Note: Please provide full details relating to the nature of illness or treatment received. Please include the amount paid or invoiced in the column provided.*

	Date of visit (DD.MM.YY)	Name of patient	Name of doctor/ practitioner	Nature of illness/ treatment received	Amount paid/ invoiced	OFFICE USE ONLY
01						
02						
03						
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05						
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07						
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09						
10						

Total claim amount **$**

Please include/attach a copy of itemised accounts and receipts showing the name of the patient, date of consultation, description of service, qualification and GST number of the provider.

3. Declaration

In completing and submitting this form you consent to the collection, disclosure and use of your information in accordance with the Privacy Act 2020, the Health Information Privacy Code and the Privacy Statement contained in the UniMed Conditions of Membership.

Are the events under this claim subject to reimbursement from another Health Insurer?*

○ Yes ○ No

I confirm:*

☐ I understand that this claim will be treated in confidence and in accordance with the terms and conditions current at the time the events under claim occurred.

☐ I consent to receiving all documentation that UniMed is required in law to give me in electronic form and I consent to UniMed communicating with me via the preferred email address specified in this claim form.

☐ I certify that the healthcare service/s was performed and all particulars shown on this claim are true and correct. I authorise UniMed to obtain any further information they may need in connection with this claim submitted by me or my listed dependants.

Signed:*

Full name | Signature | Date

*If you require more lines to itemise your claims, please refer to page 3

Details of all claims continued

Note: Please provide full details relating to the nature of illness or treatment received. Please include the amount paid or invoiced in the column provided.*

	Date of visit (DD.MM.YY)	Name of patient	Name of doctor/ practitioner	Nature of illness/ treatment received	Amount paid/ invoiced	OFFICE USE ONLY
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