

Preventative Health Services Form

Please include all relevant documents and keep copies if required, as Australian Unity will not return originals.

1. Membership details

Your Membership Number

Title Date of birth Sex M/F

Surname First Name

If your contact details have changed, please complete below:

Postal address

Suburb State Postcode

Phone (home) Mobile

Email

2. Preventative Health Services

Please include all relevant documents and keep copies if required, as Australian Unity will retain originals.

- | | | |
|--|---|--|
| <input type="checkbox"/> Personal Health Coaching
(Complete section 3, 4 & 8) | <input type="checkbox"/> Doctor Health Check
(Complete section 3, 4 & 8) | <input type="checkbox"/> Weight Loss Service
(Complete section 3, 4 & 8) |
| <input type="checkbox"/> Quit Smoking
(Complete section 4 & 5) | <input type="checkbox"/> Mammogram Screening
(Complete section 3 & 8) | <input type="checkbox"/> Bone Density Scan
(Complete section 3 & 8) |
| <input type="checkbox"/> Cervical Cancer Vaccinations
(Complete section 3 & 8) | <input type="checkbox"/> Diabetes Australia Membership
(Complete section 3 & 8) | <input type="checkbox"/> Lift for Life
(Complete section 3 & 8) |

3. Claim details

First name of patient	Date of birth	Date of service	Name of practitioner or type of service	Has the account been paid?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

4. I want to claim for

Personal Health Coaching Doctor Health Check

BELOW TO BE COMPLETED BY YOUR HEALTH PROVIDER

Declaration by your health provider

Health condition or health goals:

Diabetes Back pain Overweight/Obesity Osteoporosis Rehabilitation Cardiac Risk Factors

Other

Provider name

Provider number Date / /

As a registered medical or program provider, I certify that the above program is intended to prevent or improve the member's specified health condition and that one of the following has taken place:

- A health coaching session
- A doctor health check

Registered health provider signature

Registered health provider practice stamp

To check your eligibility, please review your product factsheet or contact Australian Unity on 13 29 39.

5. Weight Loss Service

Health condition or health goals:

Weight Watchers Sureslim Ultra Lite Curves Complete TOWN Clubs

Date commenced program / /

Date goal weight reached / /

Date 12 month goal weight maintained (within 5kg) / /

Centre attended endorsement

To check your eligibility, please review your product factsheet or contact Australian Unity on 13 29 39.

6. Quit Smoking

Please attach a receipt from one of the following providers:

Allen Carr's Easyway Quit Foundation Smokenders

Date commenced program / /

To check your eligibility, please review your product factsheet or contact Australian Unity on 13 29 39.

7. Claim payment

Australian Unity pays your claims directly into your nominated financial institution account. You only need to complete this section if your account details are different from the details we already hold.

Name and branch of financial institution	<input type="text"/>																	
Name of account holder	<input type="text"/>																	
BSB No.	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	Account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Signature of policy holder	<input type="text"/>							Date	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

8. Declaration Note

I declare the information on this claim to be true and correct. I agree to assist Australian Unity obtain all information relevant to this claim, authorise the doctors, practitioners or other relevant authorities to provide access to any records relevant to this ailment/injury to Australian Unity (including date, type of services and relevant clinical information), and consent to the release of all relevant information to a medical referee, as determined necessary by Australian Unity, for the purpose of assessment of this claim.

Signature	<input type="text"/>							Date	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Benefits are payable on claims submitted **no more than two years** after the date of service and only for periods during which a membership is financial (fully paid).

We handle your personal information in accordance with our Privacy Policy available at australianunity.com.au/privacy or by calling 13 29 39.



Return by post

Australian Unity Health
Reply Paid 91943, Melbourne VIC 3000
(No stamp is required)



Online

Send in an electronic claim via
Online Member Services at
australianunity.com.au/memberservices



Email

customerservice@australianunity.com.au



Apps

Download our iPhone or Android application
to submit your claim electronically.
Available on most covers.

Contact us

13 29 39
australianunity.com.au