CBHS HEALTH FUND

CBHS Health Fund Limited
ABN 87 087 648 717

Please complete and and return to:

By Post: CBHS Health Fund Limited
Hospital Claims
Locked Bag 5014
Parramatta NSW 2124

Fax: 02 9843 7677

Accident/Injury/Condition form

Section A – Particulars of accident/injury/condition

1. Customerdetails

Membership Number

Surname

Given name(s)

Address

State Postcode

Telephone number ( )

2. Patient's details (if different to Customer's details)

Surname

Given name(s)

Telephone

( )

3. The nature of your injury or condition

4. Is your treatment related to an accident/injury/condition? *(Including domestic, sporting, vehicle or employment)*

No ☐ ▶ Go to *Section B – Signature*

Yes ☐

5. Details of accident/injury/condition

Date of accident/ injury/condition / /

Place of accident/ injury/condition

Describe how the accident/injury/ condition occurred

When did you first seek treatment from a Health Care Provider for matters related to this accident?

Date

Name of the Provider

Type of Provider

6. Please answer the following questions:

Does your accident/injury/condition relate to the nature of your employment? No ☐ Yes ☐

Did the accident/injury/condition occur whilst at work? No ☐ Yes ☐

Did your accident/injury/condition occur whilst involved in sporting activities or training? No ☐ Yes ☐

You may be entitled to lodge a claim with Work Cover and all relevant treatment and claims should be forwarded to your employer's Insurance Company or, in the event of a motor vehicle accident, sent to Third Party Insurance company.

Note: If the Insurance Company has rejected your claim please provide CBHS with a copy of the document which will enable CBHS to correctly assess your claim.

Section B – Signature

7. *I acknowledge that I must give all relevant information as requested by CBHS Health Fund.*
I declare that the above statement to be true and correct.

Signature

Date / /

Telephone number ( )