



# Health Management Program Authorisation

Send this form along with your claim form and relevant receipts to:  
 Post: Locked Bag 5014  
 Parramatta, NSW2124  
 Fax: 02 9843 7676

Under CBHS Wellness Benefits, members can claim towards a health management program. The benefit is available to members if the health management program **is designed to improve or reduce a specific health or medical condition.**

**Please submit this form along with your completed claim form and relevant receipts for the health management program.**

**Section 1 - Details of claimant**

CBHS Membership No \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Claimant First Name \_\_\_\_\_ Claimant Surname \_\_\_\_\_

**Section 2 - To be completed by your health practitioner. (GP, Specialist, Physiotherapist or Allied Health service providers)**

Practitioners Name \_\_\_\_\_ Provider Number \_\_\_\_\_  
 Phone number (incl. area code) \_\_\_\_\_ Postcode \_\_\_\_\_

Please indicate the patient's medical condition

Please indicate the health management regime you are recommending to improve the patient's medical condition.

This regime will require:  Gym membership  Personal trainer  Pilates  Yoga

Please indicate the length of time you are recommending for this course of treatment \_\_\_\_\_ months.

**Declaration (to be completed by the practitioner)**

I declare that the information I have provided is true and correct.

Practitioners signature and practice stamp.

Date \_\_\_\_\_

**Section 3 – Additional information**

Is this claim a result of an accident or trauma:  Yes  No If 'Yes', please give the date of the event \_\_\_\_\_

Is the claimant entitled to any form of compensation, damages or payment as a result of this accident or trauma?  Yes  No

If 'Yes', please provide brief details \_\_\_\_\_

Your GP's Name \_\_\_\_\_

**Declaration of Authority, I declare that:**

- the documents attached, supporting this claim, are for services rendered to myself or a dependant listed on my membership, and
- the information I have provided is true, complete and correct, and
- the claim is received as part of a health management program intended to improve or reduce a specific health condition(s).

**I authorise CBHS Health Fund Limited to contact the provider of any service claimed and obtain any information relating to the claim.**

Signature of Member (or Authorised Partner)

Date \_\_\_\_\_

**Privacy**

How CBHS collects, uses and secures your personal information is described in the CBHS Privacy Policy.

CBHS' Privacy Policy is available at [www.cbhs.com.au](http://www.cbhs.com.au) or by calling **1300 654 123**