CBHS HEALTH

CBHS Health Fund Limited ABN 87 087 648 717

Please send this claim form and any additional information:

By Post: CBHS Health Fund Limited
Locked Bag 5014, Parramatta NSW 2124
Fax: 02 9843 7676 **Email:** claims@cbhs.com.au

Authorisation to Release Information

MEMBER AND PATIENT DETAILS

1. CBHS details

Member No.

2. Member's details

Title Mr ○ Mrs ○ Miss ○ Ms ○ Dr ○

Surname

Given name

3. Patient's details

(If the patient is the same as the member write 'as above')

Surname

Given name

7. Member's address

Street number

Suburb/Town

State/Territory Postcode

5. Problem or reason for hospitilisation

AUTHORISATION

6. I, ______ **patient/authorising person's names**

authorise my doctor/s, hospital/s, or any other authorities concerned (as listed below) with my hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all relevant information to the CBHS Health Fund Limited and its Medical Consultant/s.

Medical Practitioner details

○ **Referring General Practitioner**

Name

Address

State/Territory Postcode

Telephone ( )

○ **Specialist**

Name

Address

State/Territory Postcode

Telephone ( )

○ **Hospital**

Name

Address

State/Territory Postcode

Telephone ( )

SIGNATURE

7. If the patient is under the age of 18 years the member should sign.

Date / /

Patient / Member Signature

✗