CBHS Health Fund Limited
ABN 87 087 648 717

Health Management Program Authorisation

Send this form along with your claim form and relevant receipts to:

CBA Internal Mail: CBA 2395 001
10 Pitt St
Parramatta, NSW 2150
Post: Locked Bag 5014
Parramatta, NSW 2124
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 availbale at **www.cbhs.com.au** or by calling **1300 654 123**