

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 Surname Given name 3. Patient's details (If the patient is the same as the member write 'as above') Surname Given name Given name	Dr O	7. Member's address Street number Suburb/Town State/Territory Postcode 5. Problem or reason for hospitilisation
AUTHORISATION		
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		
Pofowing Conord Practitionar	Name	
Referring General Practitioner	Address	
	Address	State/Territory Postcode
	Telephone	()
Specialist	Name	
	Address	
		State/Territory Postcode
	Telephone	()
Hospital	Name	
	Address	
		State/Territory Postcode
	Telephone	()
CLONATURE		
SIGNATURE		
7. If the patient is under the age of 18 years the member should sign.		Patient / Member Signature
		X
Date / /		