Australian Government
Department of Defence

National ADF Family Health Program
Allied Health Claim Form

Membership number ☐☐☐☐☐☐☐☐ Date of birth ☐☐ / ☐☐ / ☐☐

Contact surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Email ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Phone (BH) ☐☐☐☐☐☐☐☐☐☐

Payment details

Tick here ☐ to have benefit paid into account as previously advised or add account details: BSB ☐☐☐☐☐☐

Account number ☐☐☐☐☐☐☐☐☐ Account name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Claim details

Please enter all details of claim that are shown on invoices/receipts. Within 'Service ID' (below), enter the two-digit number of the service performed or the ADA code (shown on invoice/receipt), if you are submitting a dental claim. Service ID codes – 00: Dental, 01: Optical, 02: Physiotherapy, 03: Chiropractic, 04: Podiatry, 07: Osteopathy, 08: Dietician, 99: All other services

Patient first name ☐☐☐☐☐☐☐☐☐☐☐☐ Date of birth ☐☐ / ☐☐ / ☐☐ Tooth ID ☐☐ ADA Code ☐☐☐

Provider number ☐☐☐☐☐☐☐ Provider fee ☐☐☐☐.☐☐ Service ID ☐☐ Date of service ☐☐ / ☐☐ / ☐☐

Patient first name ☐☐☐☐☐☐☐☐☐☐☐☐ Date of birth ☐☐ / ☐☐ / ☐☐ Tooth ID ☐☐ ADA Code ☐☐☐

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Tick here ☐ if more than 6 lines in claim – details required for first 6 claims only when original receipts attached.

Tick here ☐ if you have claimed benefits from a Private Health Insurance, HICAPs receipt or remittance attached.

Declaration

I DECLARE THAT: I am responsible for all claims in respect to this membership. I agree to fully reimburse Navy Health Ltd all benefits paid where compensation or damages have been received in relation to this claim or where a benefit has been incorrectly assessed or paid. The information in this claim is true and correct. I accept and agree to abide by the Terms and Conditions as stated by the National ADF Family Health Program. I also authorise Navy Health to contact the provider of the services to clarify any information contained in the accounts/receipts.

Signature ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date ☐☐ / ☐☐ / ☐☐

Important information

Please direct claims or enquiries to: National ADF Family Health Program – PO Box 172 Box Hill VIC 3128
Phone: 1300 561 454 | Fax: (03) 9899 4234 | Email: adffhclaims@navyhealth.com.au
Receipts will not be returned. Please retain a copy before submitting claim.