Australian Government
Department of Defence

National ADF Family Health Program
Medical and Specialists 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

Patient first name ______ D.O.B __ / __ / __ Provider number ______
Provider fee ____.__ Service date __ / __ / __ Medicare rebate ____.__ MBS item no. ______

Patient first name ______ D.O.B __ / __ / __ Provider number ______
Provider fee ____.__ Service date __ / __ / __ Medicare rebate ____.__ MBS item no. ______

Patient first name ______ D.O.B __ / __ / __ Provider number ______
Provider fee ____.__ Service date __ / __ / __ Medicare rebate ____.__ MBS item no. ______

Patient first name ______ D.O.B __ / __ / __ Provider number ______
Provider fee ____.__ Service date __ / __ / __ Medicare rebate ____.__ MBS item no. ______

Patient first name ______ D.O.B __ / __ / __ Provider number ______
Provider fee ____.__ Service date __ / __ / __ Medicare rebate ____.__ MBS item no. ______

Patient first name ______ D.O.B __ / __ / __ Provider number ______
Provider fee ____.__ Service date __ / __ / __ Medicare rebate ____.__ MBS item no. ______

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.