health.com.au

ACCIDENT AND EMERGENCY

health.com.au has received information from you (or your healthcare provider) that a claim you recently lodged may be for treatment that you have received as a result of an accident. You may be entitled to compensation for that incident, so to assess your claim correctly, please complete this form that gives health.com.au all the details we need.

Important to note: in order for us to assess this as an accident, you'll need to seek medical treatment within the first 24 hours of the accident happening. We'll need the attending doctor to fill out our Medical Practitioner Form, and we'll also need the discharge summary from your admission. The hospital will be able to supply this.

CLAIMANT DETAILS (your info)

Your health.com.au Customer Number

Name

Date of Birth *(dd/mm/yyyy)*

Email address

Phone number (include area code)

DETAILS OF ACCIDENT

Name of injured person (if different from above)

Date of Birth *(dd/mm/yyyy)*

Place of Accident

Date of Accident *(dd/mm/yyyy)*

Time of Accident *(HH:MM)*

Describe how the accident occured

DETAILS OF CLAIM

Question	Yes	No
Did this accident or injury occur whilst at work or travelling to or from work?	☐ Yes	☐ No
If yes, have you or will you lodge a claim with your employee/workers compensation?	☐ Yes	☐ No
Did this accident/injury occur when travelling in a vehicle or on public transport?	☐ Yes	☐ No
If yes, have you or will you lodge a claim with a motor vehicle accident compensation scheme or third party?	☐ Yes	☐ No
Was this accident/injury the result of negligence or violence by another person?	☐ Yes	☐ No
If yes, do you intent to pursue a Common Law Personal Injuries claim or Criminal Injuries Compensation?	☐ Yes	☐ No
Have you received a Common Law, Third Party or Workers Compensation settlement in regard to this accident?	☐ Yes	☐ No

Name of Solicitor or other Third Party (if yes)

Phone Number (include area code)

Name of Insurance Company Involved

CUSTOMER DECLARATION

I authorise health.com.au to contact any necessary persons if additional information or supporting documentation is required to establish my eligibility for benefits. I declare that the information given is true and correct.

Signature

Date

Please return to health.com.au

Email: hospitalteam@health.com.au

Fax: 03 8609 1396

Post: Locked Bag 423 Abbotsford VIC 3067