health.com.au

HEALTH MAINTENANCE CLAIM

health.com.au aims to provide practical support to help you reach your health maintenance goals. We'll cover some of the costs for health-related programs that are completed under the care of your doctor. To be eligible for a Health Maintenance benefit under the Private Health Insurance Act, the program must be recognised by health.com.au at its sole discretion, as part of a health or chronic disease management program.

The form must be signed by your GP, confirming that the program is part of a health management or chronic disease management program. Each approval is valid for a maximum of 24 months from the date the approval is signed.

Approved Health Maintenance Programs are activities such as:

- Weight Management / Quit Smoking Programs
- Gym Memberships
- Psychotherapy / Hypnotherapy
- Relevant First Aid Courses - your GP needs to indicate the condition the course will be supporting (e.g., asthma, diabetes, etc.)

Costs of food and health products are not claimable.

Make sure to get this form approved and signed by your GP before you purchase the specific program, so that everything goes smoothly when you're claiming.

STEPS TO MAKE A CLAIM:

1. **Obtain approval from your GP before undertaking any program**
2. **Start your approved health maintenance activity, and make the most of it!**
3. **Upload your completed form here, or drop an email to claims@health.com.au and we'll take it from there.**

CLAIMANT DETAILS (your info)

Your health.com.au Customer Number

Name

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

Email address

Phone *(include area code)*

SERVICE PROVIDER DETAILS (e.g. gym, studio or course provider)

Name of business

Phone (include area code)

Address (include street, suburb, state and postal code)

DECLARATION BY MEDICAL PRACTITIONER

I declare that the treatments described above are intended to be part of an approved health management or chronic disease management program.

Name of Practitioner

Telephone Number *(include area code)*

For First Aid Courses Only

Date

Signature of Medical Practitioner

CLAIM (PLEASE ATTACH RECEIPTS)

Date	Service	Service Cost

CUSTOMER DECLARATION

I declare that the information provided is true and correct. I hereby authorise the providers concerned to supply any information required to validate this claim.

Signature

Date