NATIONAL PRIVATE PATIENT HOSPITAL CLAIM FORM

Private Health Fund	HCF	Hospital Name	Macquarie University Hospital
Hospital Provider number	0017360L	Hospital Record Number	

1. PATIENT/FUND MEMBERSHIP DETAILS

Family Name of Patient	Morrison	Title	Mr
Given Names of Patient	Raymond		
Membership number	35479624	Level of Cover	
Relationship of Patient to Member	Self	Patient's Date of Birth & Age	19/08/1985 39 yrs
Family Name of Member	Morrison		
Given Names of Member	Raymond		
Residential Address of Member	40 TOLEDO CCT PORT KENNEDY WA 6172		
Is this a permanent address?	No ☐ Yes ☒	Email	ray.morrison85@hotmail.com
Telephone	H	W	M 0459570046
Full name of Admitting Medical Practitioner	Munjed Al Muderis		

2. DECLARATION CONCERNING CLAIM

PATIENT/GUARDIAN TO COMPLETE (please tick below)	No	Yes
Do you have entitlement to claim compensation or damages?	☒	☐
Have you lodged a claim for compensation or damages?	☒	☐
Did the injury or condition occur at work, going to or from work, or as a result of being at work?	☐	☒
Did the hospitalisation result from a motor vehicle accident?	☒	☐
Did the hospitalisation result from any other type of accident?	☒	☐
Does the patient have entitlement to free treatment under Australian Veterans' legislation?	☒	☐
Is the patient a full-time student dependent over 17 years and under 25 years?	☒	☐

If yes, name of educational institution			
Date patient was first aware of symptoms	24/02/2022	Date patient first consulted a doctor for symptoms	24/02/2022

Were the financial implications of your hospital charges explained prior to admission?	☐	☒
Have you signed an Election Form to elect to be treated as a private patient (PUBLIC HOSPITAL PATIENTS ONLY)	☒	☐

☒ **I hereby declare and warrant that all the above information provided in connection with this claim is true and correct**

☒ **I authorise the hospital, or any other authorities concerned with this hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all information, including Hospital Casemix Protocol information as required by the Federal Government, to the private health fund for the purpose of providing private health insurance in accordance with the fund's privacy policy.**

☒ **I authorise my health fund to pay benefits directly to the hospital.**

Patient's/Guardian's Signature **Date**