CLAIM FOR REIMBURSEMENT

For Medical, Pharmacy, and **approved** other costs (**Not Travel**)

Claimant: ____________ Claim Number: ____________ Month: ____________

Date	Item Description	Type	Receipt Attached	Total ($)	Recommended by Treating Doctor	Is this medication Pharmaceutical Benefits Scheme (PBS) approved?
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
			Yes ☐	$	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
		Total for this sheet		$ 0.00		
		Number of pages attached				

I certify that the information I have provided is true and correct.

Signed ____________

Date ___ / ___ / ___

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