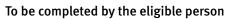
## Wigs and Hairpieces Claim Form





Please print clearly using capital letters.

| Eligible person details  |                                   |  |  |
|--|-----------------------------------|--|--|
| First name(s)  | Last na                           | me   |  |
|  |                                   |  |  |
| Date of birth  |                                   |  |  |
| Unit/flat no. Street no. Street  | name                              |  |  |
| Street no. Street  |                                   |  |  |
| Suburb City/town Postcode  |                                   |  |  |
|  |                                   |  |  |
| Contact phone number   |                                   |  |  |
|  |                                   |  |  |
| Email address  |                                   |  |  |
|  |                                   |  |  |
| Claim details  |                                   |  |  |
| ☐ Initial claim ☐ Subsequent c   | laim (Please tick relevant claim) |  |  |
| ☐ Temporary condition ☐ Permanent condition (Please tick relevant condition) |                                   |  |  |
| Date of purchase   |                                   |  |  |
| Date of purchase   |                                   |  |  |
| Item(s) purchased  |                                   |  |  |
| Total amount of purchase \$  | Note:                             | Note:  |  |
| Total amount claimed \$  | A medical certificate (if in      | A medical certificate (if initial claim) and proof of purchase must accompany this form.                                   |  |
| iotal amount danned  |                                   |  |  |
| <b>Certification</b> (Please tick the appropri                               | ate box)                          |  |  |
| ☐ I am submitting this claim on my   |                                   | h pavee number is:   |  |
|  |                                   |  |  |
| I am authorising my provider to c  | aim for this service on my behal  | r.   |  |
|  |                                   | alth care in accordance with any eligibility direction issued  |  |
|  |                                   | 000, or any eligibility direction continued by section 112 (1) from the Accident Compensation Corporation. I certify that, |  |
| as the eligible person named above, I  | ,                                 |  |  |
| Signature  |                                   | Date   |  |
|  |                                   |  |  |
|  |                                   |  |  |
| For Ministry of Health use only  |                                   | Date   |  |
| Total amount payable \$  | Checked by                        |  |  |