Client Reimbursement Claim Form

Please complete this form and email it to invoices@healthassure.com.au with attachments:

- original tax invoice(s) from your service provider
- proof of payment(s), such as a receipt

NDIS Participant Details:	
NDIS Number:	
NDIS Participant Name:	
Nominee/Claimant Details:	
Full name:	
Phone:	
Email:	
Bank Details:	
Account Name:	
BSB:	
Account Number:	

Invoice Date	**Invoice / Receipt No**	**Service / Product Description** ***(include details such as provider name, date, support category)***	**Amount**

By signing below, you agree that you have authority to claim and declare the following:

- All information provided above is true and correct including your bank details.
- Copies of original invoice(s) and receipt(s) are attached.
- All supports being claimed have been provided and paid for in full.
- All supports being claimed meet the NDIS Legislative requirements for "Reasonable & Necessary" and are approved items on the NDIS Plan.

Signature: .....

Name: .....

Date: .....