MEDICAL AND/OR OTHER EXPENSES FORM

This form is to be completed when you are seeking reimbursement of medical and/or other expenses.

Please ensure you complete this form and attach a copy of your receipts for prompt reimbursement. If the space provided below is insufficient, please attach a separate sheet.

Injured worker details

CLAIM NUMBER

SURNAME

GIVEN NAME

ADDRESS

POSTCODE

DATE OF SERVICE	SERVICE PROVIDER NAME	SERVICE PROVIDED	AMOUNT
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$

*Receipts must be attached

TOTAL $ 0.00

You can scan and attach your correspondence to an email and send to: **workerscompclaims@iag.com.au**

Please ensure our claim number is included in the subject line of your email.

Alternatively, you can use free postage within Australia (no stamp required) by addressing your envelope to:

WFI Workers Compensation Claims
Reply Paid 85245
Welshpool DC WA 6986

SIGNATURE

DATE D D / M M / Y Y