health.com.au

Medical Practitioner Certificate

PRE-EXISTING CONDITIONS

A pre-existing condition is one where the signs and symptoms of an ailment, illness or condition existed at any time during the six months before a policyholder took out a new health insurance policy or upgraded to a higher level of cover. If health.com.au has reason to believe that the policy may have had pre-existing condition, health.com.au will appoint an independent medical practitioner who'll determine whether the policyholder has a pre-existing condition, based on information provided by the treating practitioner(s). This form requests information from you, about signs and/or symptoms associated with the condition(s) requiring hospital treatment. health.com.au's appointed medical practitioner will assess the information, to allow health.com.au determine the level of health insurance benefits to which you're entitled.

YOUR GENERAL PRACTITIONER AND SPECIALIST MUST FILL OUT ONE FORM EACH.

IMPORTANT: REMEMBER TO FILL OUT ALL OF SECTION A YOURSELF, AND MAKE SURE TO SIGN IT. OTHERWISE WE CAN'T PROCEED. THANKS!

A: PATIENT CONSENT FOR RELEASE OF INFORMATION

Patient's health.com.au Customer Number

Patient Name

Date of Birth *(dd/mm/yyy)*

Address *(include street, suburb, state and postal code)*

Telephone Number *(include area code)*

I consent to the disclosure of my medical information relating to the condition(s) requiring hospital treatment to health.com.au. I also give consent for any other medical practitioner(s) who has/have seen me regarding the condition(s) to give medical information to health.com.au.

Date *(dd/mm/yyyy)*

Signature of Patient (or Guardian)

B: MEDICAL PRACTITIONER DETAILS

You are the patient's: ☐ General Practitioner ☐ Specialist

Name of Practitioner

Address *(include street, suburb, state and postal code)*

Telephone Number *(include area code)*

Date *(dd/mm/yyyy)*

Signature of Medical Practitioner

C: CERTIFICATION BY MEDICAL PRACTITITIONER

Date of Patient's First Attendance **to you** for this illness *(dd/mm/yyyy)*

When first seen **by you**, how long had signs/symptoms had been present for?

____ Days ____ Weeks ____ Months ____ Years

Signs/Symptoms Consisted of:

Principal Condition (reason for hospitalisation)

Associated Conditions (if any)

Date of Hospital Admission *(dd/mm/yyyy)*

Date to be confirmed ☐

Name of doctor who's referring the patient

Date Patient was/is being referred *(dd/mm/yyyy)*

Address of Referred/Referring Doctor *(please include street, suburb, state and postal code)*