



General Practitioner certificate



About this certificate

The only person authorised to decide whether you have a pre-existing condition is a medical or other health practitioner appointed by Defence Health. This certificate requests information from you and your treating practitioner about signs and/or symptoms associated with the condition/s requiring treatment. The medical practitioner appointed by Defence Health will consider the opinion of, and evidence presented by your treating practitioner on this certificate before making an informed assessment of pre-existing conditions. The practitioner appointed by Defence Health to review your case may need up to five business days to investigate and make an assessment.

What happens next?

You will be notified in writing of the outcome of the investigation. If your condition is assessed as pre-existing then a copy of the Defence Health appointed practitioner's report will also be forwarded to you for your records. If you have taken up hospital cover for the first time, you will not receive any benefits for a pre-existing ailment in the first twelve months of membership. If you already have hospital cover but have transferred to a higher level of cover, you may only receive the (lower) benefits that you had on your previous level of cover for a pre-existing ailment in the first twelve months on your new cover.

1 Consent by patient for disclosure of information by doctor or health fund

The information collected on this form only relates to the condition/s requiring hospitalisation at this time. The information will be used only for the purpose of determining whether the condition/s requiring hospitalisation is/are pre-existing.

Member name

Member number

Contact number

Address

State

Postcode

Patient name

Patient date of birth

Gender

 Male Female

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

Signature of patient (or parent/guardian if patient is under age 16)

Date

2 Certification by General Practitioner (This section must be completed by the first practitioner consulted)

Name of General Practitioner

Gender

 GP Dentist Other (specify)

Practice Address

State

Postcode

Contact number





2 Certification by General Practitioner (continued)

1 Date of hospital admission (or proposed admission)

/ / to / /

2 a. Principal condition (reason for hospitalisation)

b. Nature of operation (if any)

c. Associated conditions (if any)

3 Date of patient's first attendance for this illness

/ /

4 Signs or symptoms of the condition (i.e. in 2a above) when first seen

a. Consisted of

b. Had commenced on

/ /

OR

c. Had been present for

days weeks months years

5 Are you the patient's usual General Practitioner? No Yes

If Yes - did you refer the patient to a specialist? No Yes If Yes - to whom?

Name of specialist

Date of referral

/ /

Address of Specialist

State

Postcode

Contact number of Specialist

Signature of General Practitioner

Date

/ /





Specialist or Consultant Practitioner certificate



About this certificate

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What happens next?

You will be notified in writing of the outcome of the investigation. If your condition is assessed as pre-existing then a copy of the Defence Health appointed practitioner's report will also be forwarded to you for your records. If you have taken up hospital cover for the first time, you will not receive any benefits for a pre-existing ailment in the first twelve months of membership. If you already have hospital cover but have transferred to a higher level of cover, you may only receive the (lower) benefits that you had on your previous level of cover for a pre-existing ailment in the first twelve months on your new cover.

1 Consent by patient for disclosure of information by doctor or health fund

The information collected on this form only relates to the condition/s requiring hospitalisation at this time. The information will be used only for the purpose of determining whether the condition/s requiring hospitalisation is/are pre-existing.

Member name Member number

Contact number
Address State Postcode
Patient name Patient date of birth / / Gender Male Female

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

Signature of patient (or parent/guardian if patient is under age 16) Date / /

2 Certification by Specialist Practitioner (This section must be completed by the first practitioner consulted)

Name of Specialist Consultant
Speciality
Practice Address State Postcode
Contact number





2 Certification by Specialist Practitioner (continued)

1 Date of hospital admission (or proposed admission)

/ / to / /

2 a. Principal condition (reason for hospitalisation)

b. Nature of operation (if any)

c. Associated conditions (if any)

3 Date patient first attended you for this illness

/ /

4 Signs or symptoms of the condition (i.e. in 2a above) when first seen

a. Consisted of

b. Had commenced on

/ /

OR

c. Had been present for

days weeks months years

5 Are you the treating specialist for the patient? No Yes

If Yes - who referred the patient to you?

Name of referring practitioner

Date of referral

/ /

Address of referring practitioner

State

Postcode

Contact number of referring practitioner

Signature of Specialist / Consultant Practitioner

Date

/ /

