

MEDICAL PRACTITIONER CERTIFICATE

For your general practitioner

Regarding pre-existing ailments

Under the National Health Act 1953, a pre-existing ailment is an ailment, illness or condition, the signs and/or symptoms of which in the opinion of a medical practitioner appointed by the health fund, existed at any time during the 6 months preceding the day on which the contributor (patient) began contributions to their current hospital table.

This form requests information from you about signs and/or symptoms associated with the condition/s requiring hospital treatment. The medical practitioner appointed by Latrobe Health Services will use the information to make an informed PEA assessment and allow Latrobe Health Services to determine the level of health insurance benefits to which the patient is entitled. Latrobe Health Services may disclose the information to the patient as part of the evidence considered in this matter. The patient may disclose the information to the Private Health Insurance Ombudsman in the event of a complaint arising from this matter.

Consent by patient for disclosure of information by doctor to 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.

I consent to the disclosure of my medical information, relating to the condition/s requiring hospital treatment, to Latrobe Health Services. 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:	Date signed:
Full name:	
Date of birth (DD/MM/YYYY):	
Residential address:	Postcode:
Phone:	Membership number:

Certification by medical practitioner over the page

MEDICAL PRACTITIONER CERTIFICATE

Part A: Certification by medical practitioner

1	Start and end date of hospital admission (or proposed admission):				
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 (ie in 2a. as above) when first seen:				
	a. Consisted of:				
	b. had commenced on:				
	c. has been present for: days weeks months years				
5	Are you the patient's usual general practitioner? Please tick one box: ☐ Yes ☐ No				
	If Yes , did you refer the patient to a specialist? Please tick one box: ☐ Yes ☐ No				
	If Yes , to whom? Name of specialist:				
	Date of referral:		Phone:		
	Address of specialist:				

Part B: Signature

Signature:		Date signed:	
Full name:			
Address:			Postcode:
Phone:			

MEDICAL PRACTITIONER CERTIFICATE

For your specialist

Regarding pre-existing ailments

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This form requests information from you about signs and/or symptoms associated with the condition/s requiring hospital treatment. The medical practitioner appointed by Latrobe Health Services will use the information to make an informed PEA assessment and allow Latrobe Health Services to determine the level of health insurance benefits to which the patient is entitled. Latrobe Health Services may disclose the information to the patient as part of the evidence considered in this matter. The patient may disclose the information to the Private Health Insurance Ombudsman in the event of a complaint arising from this matter.

Consent by patient for disclosure of information by doctor to 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.

I consent to the disclosure of my medical information, relating to the condition/s requiring hospital treatment, to Latrobe Health Services. 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:	Date signed:
Full name:	
Date of birth (DD/MM/YYYY):	
Residential address:	Postcode:
Phone:	Membership number:

Certification by medical practitioner over the page

MEDICAL PRACTITIONER CERTIFICATE

Part A: Certification by medical practitioner

1	Start and end date of hospital admission (or proposed admission):			
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 (ie in 2a. as above) when first seen:			
	a. Consisted of:			
	b. had commenced on:			
	c. has been present for: days weeks months years			
5	Are you a specialist by whom the patient was treated? Please tick one box: ☐ Yes ☐ No			
	If Yes , who referred the patient to you? Name of referring practitioner:			
	Date of referral:		Phone:	
	Address of practitioner:			

Part B: Signature

Signature:		Date signed:	
Full name:			
Address:			Postcode:
Phone:			