Insulin pump replacement

ahm health insurance

Please ask your Specialist or Nurse Practitioner and Credentialled Diabetes Educator to complete this form if you've received an insulin pump replacement outside of a hospital. To check your eligibility for this benefit before completing the form please call us on 134 246.

1 Patient's details Please use black pen and print in UPPERCASE

Member number | Title | First names

Surname | Date of birth D D M M Y Y

2 Specialist or Nurse Practitioner and Credentialled Diabetes Educator details

Specialist's name

Address

Suburb | State | Postcode

Phone | Mobile phone | Medical Device/Human Tissue Billing Code

Date of fitting for current medical device D D M M Y Y

3 Declaration by Specialist or Nurse Practitioner and Credentialled Diabetes Educator

I confirm that the provision of this insulin pump replacement is medically necessary, that the medical device is included on the government's Prescribed List of Medical Devices and Human Tissue Products, and that the pump being replaced is not within warranty.

Specialist signature

Date: / /

4 Declaration by Member/Guardian

I declare that the information on this form is true and correct. I authorise ahm to check these details with the relevant medical device supplier or medical practitioner/health professional, including whether benefits have already been paid by previous health insurers. I acknowledge that ahm may use the information on this claim to assess and process this claim, or for purposes related to this claim, in line with the ahm Privacy Policy. I confirm that the medical device referred to on this claim form was provided by the medical practitioner that completed this form and received by the patient named on this form. I authorise ahm to contact the medical device supplier or medical practitioner in relation to the payment of the insulin pump invoice, if required.

Member/Guardian signature

Date: / /

Submitting your form

Members are not required to submit this form. Completed forms should be forwarded by the medical practitioner to the medical device supplier who will return the form to ahm on your behalf

Medical practitioners: Please complete this form and pass on to the medical device supplier

Suppliers: Please email the form to info@ahm.com.au or alternatively you can post this completed form to ahm health insurance Locked Bag 4, Wetherill Park NSM 2164