SPECIALIST CERTIFICATE

Please fax this form to 1300 329 246 or post to ahm Health Insurance. Locked Bag 4, Wetherill Park BC, NSW 2164 or email to info@ahm.com.au

This form is to be completed by your Specialist to enable an independent Medical Practitioner appointed by ahm to assess whether or not the condition requiring hospitalisation was pre-existing.

AUTHORISATION BY PATIENT TO RELEASE INFORMATION

I,_____ authorise my doctor(s), hospital(s), or any other persons or authorities concerned with my hospitalisation, ailment, illness or condition, to supply all relevant information to ahm Health Insurance and/or its independent Medical Practitioner.

Patient signature:_____ Date:_____

(Must be signed by principal member/guardian if the patient is under 18 years of age)

PATIENT DETAILS

Principal member:_____ Member number:_____ Ref: _____

Patient: _____ Transfer/Upgrade: Current Cover start date:_____

Reason for hospitalistion:_____

Address:_____

State:_____ Postcode:_____ Phone:_____ Patient DOB: ____/____/____

Email:_____

SPECIALIST DETAILS

Name of specialist: _____ Specialisation:_____

Address of practice:_____

State:_____ Postcode: _____ Phone:_____ Email: _____

1. Date of hospital admission (or proposed admission): ____/____/____ to ____/____/____

2. Principal condition (reason for hospitalisation):_____

   a. Nature of operation (if any): _____

   b. 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:_____

   c. Had been present for:_____ days _____weeks _____months_____years

5. Are you the treating specialist for the patient? Yes / No (Please circle)

6. If yes, who referred the patient to you?

Name of referring practitioner:_____ Date referred:____/____/____

Address of referring practitioner: _____

State:_____P/C:_____ Phone/Fax: ( )_____ Email: _____

Specialist's signature:_____ Date:____/____/____

MEDICAL PRACTITIONER CERTIFICATE

Please fax this form to 1300 329 246 or post to ahm Health Insurance. Reply Paid 75885, Matraville NSW 2036 or email to info@ahm.com.au

This form is to be completed by your General Practitioner to enable an independent Medical Practitioner appointed by ahm to assess whether or not the condition requiring hospitalisation was pre-existing.

AUTHORISATION BY PATIENT TO RELEASE INFORMATION

I,_____ authorise my doctor(s), hospital(s), or any other persons or authorities concerned with my hospitalisation, ailment, illness or condition, to supply all relevant information to ahm Health Insurance and/or its independent Medical Practitioner.

Patient signature:_____ Date:_____

(Must be signed by principal member/guardian if the patient is under 18 years of age)

PATIENT DETAILS

Principal member:_____ Member number:_____ Ref:_____

Patient:_____ Transfer/Upgrade:_____ Current Cover start date:_____

Reason for hospitalisation:_____

Address:_____

State:_____ Postcode:_____ Phone:_____ Patient DOB: ___/___/___

Email:_____

GENERAL PRACTITIONER DETAILS

Name of practitioner:_____ ☐ GP ☐ Dentist ☐ Optometrist ☐ Other (specify)_____

Address of practice:_____

State:_____ Postcode:_____ Phone:_____ Email:_____

1. Date of hospital admission (or proposed admission): ___/___/___ to ___/___/___
2. Principal condition (reason for hospitalisation):_____
   a. Nature of operation (if any):_____
   b. 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:_____
   c. Had been present for:_____days_____weeks_____months_____years
5. Are you the patient's usual General Practitioner? Yes / No (Please circle)
6. Did you refer the patient to a specialist? Yes / No (Please circle)

Name of specialist:_____ Date referred: ___/___/___

Address of specialist:_____

State:_____ P/C:_____ Phone/Fax: ( )_____ Email:_____

Practitioner's signature:_____ Date: ___/___/___