Request for discretionary funding

ahm health insurance

This form is to be used by partner private hospitals seeking an additional benefit for services falling outside the parameters of their hospital contract.

Please note: Part A and B of this form include mandatory fields that must be completed for each application. Assessment of application will only take place when all sections of the form have been completed. Incomplete information may affect a timely response to the application. Supplier invoices and/or quotes must be scanned and attached.

Submitting your form
Please email to **info@ahm.com.au** and add **'Discretionary funding'** in the email subject. Responses will be emailed to the contact person detailed in this application.

Part A (To be completed by the hospital)

Hospital name & provider number	
Contact person	
Contact person's phone number	
Contact person's fax number	
Contact's email address	
Member name	
Member number	
Member date of birth	
Date & time request sent	

Part B (To be completed by the prescribing medical practitioner or delegate)

Medical practitioner			
Phone number			
Email address			
Patient admission date		Anticipated discharge date	
		Funding Commencement date	
Principal diagnosis			
Provisional DRG			
Additional diagnoses or co-morbidities			
Surgical procedure or treatment provided			
MBS Item No.			

In addition to Part A and Part B please complete the applicable section depending on the nature of the request.

Admitted services (in-patient)

Section 1 – Non PBS High Cost Medications
Section 2 – Non Listed Prostheses and High Cost Disposables

PLEASE NOTE: If the services requested are not listed as per above then please contact ahm health insurance with your enquiry.

Admitted services (in-patient)

Section 1 – Non PBS High Cost Medication

Name of Medication			
Dose required (per day)		How is medication administered?	
Rationale for use			
Previous medications pre-scribed			
Anticipated commencement date		Anticipated duration of therapy	
On what basis will the member receive therapy			
Cost per daily dose (wholesale)	$	Total cost of treatment	$
Additional information			

Section 2 – Non Listed Prosthesis and High Cost Disposables

Anticipated date of procedure **(NOTE: where surgery has already been performed approval will not be given except where, in the case of an emergency procedure, prior notification was not practical)**	
Requested Item (name and description)	
Manufacturer/supplier name	
Proposed charge per item	
Supplier Invoice attached	☐ YES ☐ NO
Rationale for use	
Is there a comparator item available?	☐ YES ☐ NO
If there is a comparator available what is the evidence to support the use of this item in preference to the comparator?	
Is this item registered with the TGA?	☐ YES ☐ NO
If the item is not registered with the TGA, is there a Special Access Scheme Authorisation?	
Additional information	

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