Medical Practitioner Certificate for Pre-Existing Conditions

Under the Private Health Insurance Act 2007, a pre-existing condition 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 six months prior to the day on which the contributor (patient) began contributions to their current hospital cover.

This form requests information from you about signs and/or symptoms associated with the condition(s) requiring hospital treatment. The medical practitioner appointed by the health fund will use this information to make an informed assessment and allow the health fund to determine the level of health insurance benefits to which the patient is entitled. The health fund 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 hospitalization at this time. The information will be used only for the purpose of determining whether the condition/s requiring hospitalization is/are pre-existing.
I, consent to the disclosure of my medical information relating to the condition(s) requiring hospital treatment to ACA Health Benefits Fund. I also give consent for any other practitioner(s) who has/have seen me regarding the condition(s) to give medical information to the health fund.

Member #:	Name:	
Address:		
Suburb:	State:	Post Code:
Phone:	Date of Birth: / /	
Signature:	**Date: / /**	

CERTIFICATION by Medical Practitioner

1. DATE of HOSPITAL Admission (or proposed Admission): / / to / /

2. a. PRINCIPAL CONDITION (reason for hospitalization):_____
   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. 2a above) when first seen:
   a. consisted of_____
   b. had commenced on: / /
   c. had been presented for, _____ days _____ weeks _____ months _____ years

5. Are you the patients usual General Practitioner? ☐ Yes ☐ No
   If YES – Did you refer the patient to a specialist? ☐ Yes ☐ No If YES - To Whom? _____
   Date of Referral: / / Name of Specialist: _____
   Address of Specialist _____Phone: ( )_____

6. Are you a Specialist by whom the patient was treated? ☐ Yes ☐ No
   If YES: By whom was the patient referred to you?
   Date of Referral: / / Name of referring Practitioner: _____
   Address of Practitioner: _____Phone: ( )_____

Medical Practitioner Information

Name: Dr		
Address:		Phone ( )
Suburb:	State:	Post Code:
Signature:		**Date: / /**

Please return to: ACA Health Benefits Fund to info@acahealth.com.au OR Locked Bag 2014 Wahroonga NSW 2076