





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 #: 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): d. Associated Conditions (if any): d. Associated Conditions (if any): d. Associated of Detail 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? des down of the Specialist of Specialist des	give medical information to the	neaith iuna.					
Suburb: State: Post Code: Phone: Date of Birth: / / Signature: Date of Birth: / / CERTIFICATION by Medical Practitioner 1. DATE of HOSPITAL Admission (or proposed Admission): / / to / / 2. a. PRINCIPAL CONDITION (reason for hospitalization):	Member #:	Name:					
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): d. 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	Address:						
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c. had been presented for, days weeks months years 5. Are you the patients usual General Practitioner?							
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:							
If YES – Did you refer the patient to a specialist?	c. had been presented for,	days week	s month	ns y	ears		
Date of Referral: / / Name of Specialist:	5. Are you the patients usual Ge	eneral Practitioner? Yes	s No				
Address of Specialist			_	- To Whom?			
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:							<u> </u>
If YES: By whom was the patient referred to you? Date of Referral: / / Name of referring Practitioner:	Address of Specialist				Phone:	()	
Date of Referral: / / Name of referring Practitioner:			Yes No				
Address of Practitioner:Phone: ()							
Medical Practitioner Information Name: Dr Address: Phone () Suburb: State: Post Code:						,	
Name: Dr Address: Phone () Suburb: State: Post Code:	Address of Practitioner:				Phone: ()	
Address: Phone () Suburb: State: Post Code:	Medical Practitioner Info	rmation					
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