Overseas Visitors Medical Authority Form

- Please complete and sign this medical authority form to provide us with the relevant details we need to assess your claim.
- The medical report on the reverse is **to be completed and signed by the doctor you first consulted** in relation to the condition which requires treatment (unless instructed otherwise) and returned together with this medical authority form.
- Note: Australian Unity will not pay any fee you may be charged for the completion of the medical report.

1 Your personal details — Complete

Membership number

Title | Surname | First name | Date of birth

Residential address

Suburb | State | Postcode

Medical condition (reason for hospitalisation or treatment)

2 Medical provider details — Complete

Name of referring practitioner | Telephone

Address of referring practitioner | Suburb | State | Postcode

Name of specialist | Telephone

Address of specialist | Suburb | State | Postcode

Name of hospital | Location of hospital

Other relevant person/authority | Telephone

Address | Suburb | State | Postcode

3 Declaration — Sign

This form requests information from you about signs or symptoms associated with the condition requiring treatment. Australian Unity's appointed medical advisor will use the information to make an assessment if your treatment relates to a pre-existing or accident related condition and allows us to determine if you are covered under your health cover for the treatment.

I consent to the disclosure of my medical information relating to the condition requiring hospital treatment at this time to Australian Unity. The information will be used only for the purpose of determining whether the condition requiring treatment is a pre-existing or accident related condition. I also give consent for any other medical practitioners who have seen me regarding the condition to give medical information to Australian Unity.

Signature of member — SIGN HERE

Date — D D / M M / Y Y

Note: Member signature if 18 years of age or over, parent or guardian if under 18 years of age.

A **pre-existing** condition is an illness, ailment or condition where the signs or symptoms existed up to six months before and on the day you joined Australian Unity or upgraded your cover, irrespective of whether you were aware of it.

We need you to get your first consulting doctor (eg your dentist, GP or specialist) to complete the medical report. The report will help our appointed medical advisor assess if your treatment relates to a pre-existing condition. You should ask us to carry out this assessment before going into hospital.

Accident means any injury sustained as a result of unintentional, unexpected actions or events, which requires medical attention from a registered medical practitioner within seven (7) days of the event, but excludes injuries arising out of: surgical procedures; unforeseen illness; pregnancy; alcohol or drug use; and aggravation of an underlying condition or injury.

If your health cover provides for accident related treatment, your injury or condition must have occurred after you joined your current level of cover to qualify for full accident cover.

Returning your documents:

Mail: Australian Unity Claims Department, Reply Paid 9945, Melbourne VIC 8060 (no stamp required)
Email: customerservice@australianunity.com.au

If you are returning your documents by email, please ensure scanned images are high resolution and in .pdf or .jpeg format.
Photos of reports will not be accepted.

Medical Report

Australian Unity

- Australian Unity will not pay any fee you may be charged for the completion of the medical report.
- This report must be completed legibly and in its entirety in order for Australian Unity to assess the claim.

4 Doctor's details

Complete (by first consulting doctor)

Name

OR Doctor's stamp

Address

State | Postcode | Telephone

5 Patient details

Complete (by first consulting doctor)

Title | Surname | First name | Date of birth

Principal condition (reason for hospitalisation or treatment)

Nature of operation (if any)

Date of procedure or admission D D / M M / Y Y

Date of original consultation in relation to this condition D D / M M / Y Y

Is this condition related to a specific accident? ☐ Yes ☐ No

If yes, describe how accident occurred

Date of accident D D / M M / Y Y

Were you the first doctor consulted in relation to this condition? ☐ Yes ☐ No

Are you the patient's usual General Practitioner? ☐ Yes ☐ No

Did you refer the patient to a specialist? ☐ Yes ☐ No

If yes, name of specialist

Date of referral D D / M M / Y Y

Are you a specialist by whom the patient was treated? ☐ Yes ☐ No

If yes, name of referring practitioner

Date of referral D D / M M / Y Y

6 Patient medical history

Complete and Sign (by first consulting doctor)

Please give a brief medical history of matters related to the condition stated above with particular mention of the date of onset of signs or symptoms and the treatment recommended or carried out along with a list of all current medications. Attach additional information if required.

Related history

How long were the signs or symptoms present **at the time of the first consultation** with the patient? (Please be specific)

years / months / weeks / days / hours (Circle one)

How long has the patient been attending this practice?

years / months / weeks / days / hours (Circle one)

Is there any associated illness or condition which may require further treatment? ☐ Yes ☐ No

If yes, please specify

Doctor's signature

SIGN HERE

Date D D / M M / Y Y