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 page 3 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

Membership Number

Title [X] Mr [X] Mrs [X] Ms [X] Miss [X] Dr

Date of birth D D / M M / Y Y Y Y

Surname

First name

Residential address (no PO Box)

Suburb

State

Postcode

Medical condition

(reason for hospitalisation or treatment)

2. Medical provider details

Name of referring practitioner

Phone

Address of referring practitioner

Suburb

State

Postcode

Name of specialist

Phone

Address of specialist

Suburb

State

Postcode

Name of hospital

Location of hospital

Other relevant person/authority

Phone

Address

Suburb

State

Postcode

Please turn over page ›

 Australian Unity Health Limited ABN 13 078 722 568 | 114 Albert Road, South Melbourne VIC 3205

3. Declaration

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. Australian Unity may disclose the information to you and you may disclose information to the Private Health Insurance Ombudsman in the event of a complaint arising.

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

Date D D / M M / Y Y 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.

You've been sent the medical report because you have made or intended to make a hospital claim in the first 12 months of your membership. 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 an unplanned and unforeseen event, occurring by chance, and leading to bodily injuries caused solely and directly by an external force or object requiring treatment from a Medical Practitioner (defined here as a medical doctor who is not the member or a relative of the Member) within 7 days of the event, but excludes injuries arising out of: surgical procedures; unforeseen illness; pregnancy; 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.

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

Name

Address

Suburb

State ☐☐☐ Postcode ☐☐☐☐

Phone

OR Doctors Stamp

5. Patient details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

Date of birth D D / M M / Y Y Y Y

Surname

First name

Principal condition

(reason for hospitalisation or treatment)

Nature of operation (if any)

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

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

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

If yes, please describe how accident occurred

Date of accident D D / M M / Y Y 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 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 Y Y

Please turn over page ›

6. Patient medical history

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. 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? [X] Yes [X] No

If yes, please specify

Doctor's signature

Date D D / M M / Y Y Y Y

Return by post

Australian Unity, Claims Department
Reply Paid 9945, Melbourne VIC 8060
(No stamp is 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.

Contact us

13 29 39

australianunity.com.au