Latrobe Health Services Limited ABN 94 137 187 010
Reply Paid 41, Morwell VIC 3840
info@lhs.com.au | latrobehealth.com.au
**Member Service Enquiries 1300 362 144**

# Latrobe Accident Advantage Form

**For completion by your treating health provider**

NOTE: This form does not relate to 'Healthy Start', 'School Accident Top Up', or 'Accident Top Extras' programs offered by Latrobe Health.

## Important information regarding accidents

An accident means an unplanned, unintentional, and unexpected event, occurring by chance and caused by external force or object resulting in a physical injury requiring immediate treatment.

This does not include any illness, an injury or condition resulting from any

complications of treatment or surgery, any injury or condition resulting from the effects of alcohol or drugs of addiction, pregnancy, or the aggravation of an existing physical injury or condition.

### Requirements for coverage:

The accident must have occurred after joining Latrobe Health, with treatment sought at an Emergency Department or from a Doctor within 72 hours of the accident.

This form must be submitted to Latrobe Health within 21 days of the accident occurring, and treatment is coverable for up to 90 days from date of accident.

All treatment must be directly related to the injury sustained at the time of the accident for benefits to be paid.

## **Consent by patient** for disclosure of information by health provider

The information collected on this form only relates to the accident causing a physical injury that requires treatment. The information will be used only for the purpose of recording the details of the accident and injury should treatment be required within 90 days of the date of the accident.

- I consent to the disclosure of my medical information, relating to the accident and physical injury, to Latrobe Health Services.
- I also consent for any other registered health practitioner(s) who has/have seen me regarding the condition/s to give medical information to Latrobe Health Services.
- I declare that the information stated regarding this accident and injury are correct. I understand that there are penalties for giving false or misleading information.

Signature: _____ Date: _____

Name: _____ D.O.B.: _____

Address: _____ State: _____ Postcode: _____

Phone: _____ Membership no.: _____

## **Certification by health provider** over the page

Private Health Insurance Code of Conduct

Latrobe Health Services
proudly supports and complies with the
Private Health Insurance Code of Conduct

Latrobe HEALTH SERVICES

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# Certification by health provider

To be **lodged within 21 days** of the accident.

**1:** Date / time of accident _____

**2:** Details of the accident (where, what and how) _____

_____

**a:** Mechanism of injury _____

_____

**b:** Details of acute physical injury _____

_____

**3:** Date of first attendance for this physical injury _____

**c:** Treatment plan for physical injury:

**a:** Immediate _____

_____

**b:** Possible future (note: Accident Advantage is only coverable for up to 90 days from date of accident) ____

_____

**5:** Did this accident occur at work? Y ☐ N ☐ Please tick one box

If Yes, have you lodged a claim? Y ☐ N ☐ Please tick one box

Was this a road traffic accident? Y ☐ N ☐ Please tick one box

If Yes, have you lodged a Transport Accident claim? Y ☐ N ☐ Please tick one box

# Health provider declaration

I declare that the information stated regarding this accident and injuries are correct.

Signature: _____ Date: _____

Name: _____

Address: _____

_____

State: _____ Postcode: _____ Phone: _____