

Latrobe
HEALTH SERVICES
EveryBody benefits from health cover

Reply Paid 41, Morwell VIC 3840 Email: info@lhs.com.au Website: latrobehealth.com.au

Member Service enquiries: 1300 362 144

Medical Practitioner Certificate For your general practitioner

Regarding pre-existing ailments

Under the National Health Act 1953, a pre-existing ailment 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 6 months preceding the day on which the contributor (patient) began contributions to their current hospital table.

This form requests information from you about signs and/or symptoms associated with the condition/s requiring hospital treatment. The medical practitioner appointed by Latrobe will use the information to make an informed PEA assessment and allow Latrobe to determine the level of health insurance benefits to which the patient is entitled. Latrobe 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 hospitalisation at this time. The information will be used only for the purpose of determining whether the condition/s requiring hospitalisation is/are pre-existing.

I consent to the disclosure of my medical information, relating to the condition/s requiring hospital treatment, to Latrobe Health Services.

I also give consent for any other medical practitioner(s) who has/have seen me regarding the condition/s to give medical information to the health fund.

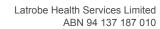
Signature		Date	
Name		D.O.B	
Address		State	Postcode
Phone	Membership No		

CERTIFICATION by medical practitioner over the page











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CERTIFICATION by medical practitioner

c Associated conditions (if any) 3 Date of patient's first attendance for this illness 4 Signs or symptoms of the condition (ie in 2a. as above) when first seen:	
Date of patient's first attendance for this illness Signs or symptoms of the condition (ie in 2a. as above) when first seen:	
4 Signs or symptoms of the condition (ie in 2a. as above) when first seen:	
a Consisted of	
b had commenced on	
c has been present fordaysweeksmonthsyears	
5 Are you the patient's usual general practitioner? Y Please tick one box	
If Yes , did you refer the patient to a specialist? Y Please tick one box	
If Yes , to whom?	
Name of specialist	
Date of referral Phone	
Address of specialist	
Signature Date	
Name	
Address	
State Postcode Phone	



Latrobe Health Services Limited ABN 94 137 187 010

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Medical Practitioner Certificate

For your specialist

Regarding pre-existing ailments

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This form requests information from you about signs and/or symptoms associated with the condition/s requiring hospital treatment. The medical practitioner appointed by Latrobe will use the information to make an informed PEA assessment and allow Latrobe to determine the level of health insurance benefits to which the patient is entitled. Latrobe 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 hospitalisation at this time. The information will be used only for the purpose of determining whether the condition/s requiring hospitalisation is/are pre-existing.

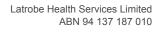
I consent to the disclosure of my medical information, relating to the condition/s requiring hospital treatment, to Latrobe Health Services.

I also give consent for any other medical practitioner(s) who has/have seen me regarding the condition/s to give medical information to the health fund.

Signature		Date	
Name		D.O.B	
Address		State	Postcode
Phone	Membership No		

CERTIFICATION by medical practitioner over the page







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CERTIFICATION by medical practitioner

1	Date of hospital admission (or proposed admission)to
2 a	Principal condition (reason for hospitalisation)
b	Nature of operation (if any)
С	Associated conditions (if any)
3	Date of patient's first attendance for this illness
4	Signs or symptoms of the condition (ie in 2a. as above) when first seen:
а	Consisted of
b c	had commenced on has been present for days weeks months years
5	Are you a specialist by whom the patient was treated? If Yes , who referred the patient to you? Name of referring practitioner
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5	If Yes , who referred the patient to you? Name of referring practitioner Date of referral Phone
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Sigr	If Yes, who referred the patient to you? Name of referring practitioner Date of referral Phone Address of practitioner Date Date
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