HEALTHIER, LONGER, BETTER LIVES

AIA Health Insurance

MEDICAL PRACTITIONER CERTIFICATE - GENERAL PRACTITIONER

Please use black pen and print upper case.
Avoid contact with the edge of the box.

A B C D

Consent by patient for release of information

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 AIA Health Insurance. 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 name

Membership number

Address

Suburb

State

Postcode

Phone

Date of birth ☐☐/☐☐/☐☐☐☐

Signature

Date ☐☐/☐☐/☐☐☐☐

Certification by General Practitioner

Patient name

1. DATE of HOSPITAL admission (or proposed admission) ☐☐/☐☐/☐☐☐☐ to ☐☐/☐☐/☐☐☐☐

2. a. Principal condition

2. b. Nature of operation (if any)

2. c. Associated conditions (if any)

3. Date of patient's FIRST attendance for this illness ☐☐/☐☐/☐☐☐☐

4. Signs or symptoms of the condition (i.e. in 2a above) when first seen

a. consisted of

b. had commenced on ☐☐/☐☐/☐☐☐☐

c. had been present for ☐☐ days / ☐☐ weeks / ☐☐ months / ☐☐ years

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5. Are you the patient's usual general practitioner? (please tick) ☐ Yes ☐ No

If YES – Did you refer the patient to a specialist? (please tick) ☐ Yes ☐ No

If YES – To whom? Name of specialist

Date of referral DD/MM/YYYY

Address of specialist

General Practitioner's signature

General Practitioner

Phone

Address

Signature

Date DD/MM/YYYY

Please return your completed and signed form to AIA Health via email: health.claims@aia.com.au or post: AIA Health, PO Box 7302, Melbourne VIC 3004