HEALTHIER, LONGER, BETTER LIVES

AIA Health Insurance

MEDICAL PRACTITIONER CERTIFICATE - TREATING SPECIALIST

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 Treating specialist

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

Continued on next page

5. Are you the specialist by whom the patient was treated? (please tick) ☐ Yes ☐ No

If YES – By whom was the patient referred to you? Referring practitioner

Date of referral

Address of specialist

Treating specialist's signature

Treating specialist

Phone

Address

Signature

Date

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