PRE-EXISTING CONDITION CERTIFICATE FORM

TEACHERS HEALTH

UPDATED AUGUST 2018

CHECKLIST

- Complete these forms in conjunction with both your GP and your treating specialist/surgeon
- Consent by patient declaration must be completed on both certificates
- Separate certification must be completed by GP or referring practitioner
- Separate certification must be completed by treating specialist
- Submit both certificates to the Fund ensuring that all declarations are signed
- Leaving a section blank or without the required information will delay the decision

MORE INFORMATION

Under the Private Health Insurance Act 2007, 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 six 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 the health fund will use the information to make an informed PEC assessment and allow the health fund to determine the level of health insurance benefits to which the patient is entitled.

The health fund 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.

For further information, visit teachershealth.com.au

SUBMITTING YOUR FORMS

You can submit your Pre–Existing Condition Certificate and any associated documentation by:

Member app	**Download at teachershealth.com.au/app**
Email	**preexistingcertificate@teachershealth.com.au**
Mail	**GPO Box 9812, Sydney NSW 2001**

Find out more about claiming at teachershealth.com.au

MEDICAL PRACTITIONER CERTIFICATE - GP OR REFERRING PRACTITIONER

A. CONSENT BY PATIENT FOR DISCLOSURE OF INFORMATION BY DOCTOR TO TEACHERS HEALTH

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

Member number | | | | | | | | | Date of birth D D / M M / Y Y Y Y

Patient's name

Signature of patient or parent/guardian

Date D D / M M / Y Y Y Y

B. CERTIFICATION BY GP

1. Date of hospital admission (or proposed admission) D D / M M / Y Y Y Y to D D / M M / Y Y Y Y
2. a. Principal condition (reason for hospitalisation)
   b. Nature of operation (if any)
   c. Associated conditions (if any)
3. Date of patient's first attendance for this illness D D / M M / Y Y Y Y
4. Signs or symptoms of the condition (i.e. In 2a. above) when first seen:
   a. Consisted of
   b. had commenced on D D / M M / Y Y Y Y
   c. had been present for ____ days ____ weeks ____ months ____ years
5. Are you the patient's usual general practitioner? ◯ Yes ◯ No

   Did you refer the patient to a specialist? ◯ Yes ◯ No

   If yes, to whom? Name of specialist

   Date of referral D D / M M / Y Y Y Y

   Address of specialist

   Suburb/town State Postcode

   Phone number of specialist

C. DECLARATION

Name of doctor

Address of doctor

Suburb/town State Postcode

Phone number of doctor

Signature

Date D D / M M / Y Y Y Y

WHAT NEXT? Once form is completed please attach supporting documents and send to **GPO Box, 9812 Sydney NSW 2001** or **preexistingcertificate@teachershealth.com.au**

MEDICAL PRACTITIONER CERTIFICATE - TREATING SPECIALIST / SURGEON

A. CONSENT BY PATIENT FOR DISCLOSURE OF INFORMATION BY DOCTOR TO TEACHERS HEALTH

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

Member number | | | | | | | | | Date of birth D D / M M / Y Y Y Y

Patient's name

Signature of patient or parent/guardian

Date D D / M M / Y Y Y Y

B. CERTIFICATION BY TREATING SPECIALIST / SURGEON

1. Date of hospital admission (or proposed admission) D D / M M / Y Y Y Y to D D / M M / Y Y Y Y
2. a. Principal condition (reason for hospitalisation)
   b. Nature of operation (if any)
   c. Associated conditions (if any)
3. Date of patient's first attendance for this illness D D / M M / Y Y Y Y
4. Signs or symptoms of the condition (i.e. In 2a. above) when first seen:
   a. Consisted of
   b. had commenced on D D / M M / Y Y Y Y
   c. had been present for ____ days ____ weeks ____ months ____ years
5. Are you a specialist by whom the patient was treated? ◯ Yes ◯ No

   If yes, by whom was the patient referred to you?

   Date of referral D D / M M / Y Y Y Y Name of referring practitioner

   Address of practitioner

   Suburb/town State Postcode

   Phone number of practitioner

C. DECLARATION

Name of doctor

Address of doctor

Suburb/town State Postcode

Phone number of doctor

Signature

Date D D / M M / Y Y Y Y

WHAT NEXT? Once form is completed please attach supporting documents and send to **GPO Box, 9812 Sydney NSW 2001** or **preexistingcertificate@teachershealth.com.au**