Medical Practitioner Certificate regarding 'Pre-Existing Conditions'

A Pre-Existing Condition means an ailment, illness or condition that, in the opinion of a medical advisor appointed by Westfund, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy. This certificate is to assist in determining the level of health insurance benefits which will apply when hospitalisation is required for a member of less than twelve months on their current level of cover.

How to complete form

Complete the consent section on each form before sending to your medical practitioners. Please contact your health practitioner and treating specialist as soon as possible, as an appointment may be required to finalise the completion of this form.

PART 1: Health Practitioner. To be completed and signed by your referring health practitioner i.e. General Practitioner, Dentist, Optometrist.

PART 2: Specialist Medical Practitioner. To be completed and signed by your treating specialist.

Return forms to Westfund

Once the two sections have been completed, please return to Westfund using one of the below options:

By email: enquiries@westfund.com.au

By post: Westfund Health Insurance, PO Box 235, Lithgow NSW 2790

Care Centre: Drop in at your local Westfund Care Centre

What happens next?

Once all of the information is submitted to the medical advisor, it may take up to 10 working days to receive an assessment. We will contact you once we have received a response.

PLEASE NOTE: It is important to confirm your eligibility for benefits BEFORE you proceed with your admission. Ensuring both your health practitioner and treating specialist have completed and submitted the required certificates will assist in determining what out-of-pocket costs may apply.

Our Privacy Policy contains information about use and disclosure of personal information, how you may access and seek correction of your personal information, how you may make a complaint about privacy, and how we will respond to your complaint. Westfund's Privacy Policy is available on our website www.westfund.com.au and at any of our Care Centres.

Westfund Head Office 59 Read Ave, Lithgow NSW 2790. PO Box 235, Lithgow NSW 2790. Phone 1300 937 838 Email enquiries@westfund.com.au
Westfund Limited ABN 55 002 080 864

Medical Practitioner Certificate regarding 'Pre-Existing Conditions'

Part 1 - Health Practitioner

Please complete and sign the information in the box below, then forward it to your referring health practitioner e.g General Practitioner, Dentist, Optometrist, etc to complete the remainder of this certificate. The information collected on this form only relates to the condition/s requiring hospitalisation at this time. The information will only be used for the purpose of determining whether the condition/s requiring hospitalisation is/are pre-existing.

I consent to the disclosure of medical information relating to the condition/s requiring hospital treatment to Westfund Health Insurance. 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 of Patient or Parent/Guardian: _____ Date: ___/___/___ (Day Month Year)

Membership Number: _____ Date of Birth: ___/___/___ (Day Month Year)

Patient Full Name: _____

Home Address: _____

_____ State: _____ Post Code: _____

Phone Number: _____ Email: _____

INFORMATION FOR HEALTH PRACTITIONER

Name of Health Practitioner: _____

Contact phone number: _____ Email: _____

Address: _____

_____ State: _____ Post Code: _____

Date (or Proposed Date) of Hospital Admission: ___/___/___ (Day Month Year) to ___/___/___ (Day Month Year)

Principal Condition (reason for hospitalisation): _____

Nature of Operation (if any): _____

Associated Conditions (if any): _____

Date of patient's first attendance for this condition: ___/___/___ (Day Month Year)

Signs and symptoms of condition when first seen consisted of: _____

_____

_____

These signs and symptoms had commenced on: ___/___/___ (Day Month Year)

These signs and symptoms had been present for: _____ days _____ weeks _____ months _____ years

To whom did you refer the patient to?

Name of Specialist: _____

Address of Specialist: _____

_____ State: _____ Post Code: _____

Phone Number: _____ Date of Referral: ___/___/___ (Day Month Year)

I certify that all information provided for the Patient named above in this form is true and correct.

Signature: _____ Date: ___/___/___ (Day Month Year)

Medical Practitioner Certificate regarding 'Pre-Existing Conditions'

Part 2 - Specialist Medical Practitioner

Please complete and sign the information in the box below, then forward it to your specialist medical practitioner to complete the remainder of this certificate. The information collected on this form only relates to the condition/s requiring hospitalisation at this time. The information will only be used for the purpose of determining whether the condition/s requiring hospitalisation is/are pre-existing.

I consent to the disclosure of medical information relating to the condition/s requiring hospital treatment to Westfund Health Insurance. 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 of Patient or Parent/Guardian: _____ Date: ___/___/___ (Day / Month / Year)

Membership Number: _____ Date of Birth: ___/___/___ (Day / Month / Year)

Patient Full Name: _____

Home Address: _____

_____ State: _____ Post Code: _____

Phone Number: _____ Email: _____

INFORMATION FOR SPECIALIST MEDICAL PRACTITIONER

Name of Specialist Medical Practitioner: _____

Contact phone number: _____ Email: _____

Address: _____

_____ State: _____ Post Code: _____

Date (or Proposed Date) of Hospital Admission: ___/___/___ (Day / Month / Year) to ___/___/___ (Day / Month / Year)

Principal Condition (reason for hospitalisation): _____

Nature of Operation (if any): _____

Associated Conditions (if any): _____

Date of patient's first attendance for this condition: ___/___/___ (Day / Month / Year)

Signs and symptoms of condition when first seen consisted of: _____

_____

_____

These signs and symptoms had commenced on: ___/___/___ (Day / Month / Year)

These signs and symptoms had been present for: _____ days _____ weeks _____ months _____ years

By whom was this patient referred?

Name of Referring Practitioner: _____

Address of Practitioner: _____

_____ State: _____ Post Code: _____

Phone Number: _____ Date of Referral: ___/___/___ (Day / Month / Year)

I certify that all information provided for the Patient named above in this form is true and correct.

Signature: _____ Date: ___/___/___ (Day / Month / Year)