# Liberty Health Cover
## Oncology Application Form

LIBERTY

LIFE INVESTMENTS INSURANCE **HEALTH** PROPERTIES ADVICE

FOR OFFICIAL USE ONLY Member/ policy number

**Important: please read the following before completing this application form**
- Please write clearly using capital and block letters.
- Please submit your completed form to our Liberty Health Cover in-country office.

### 1. PERSONAL DETAILS | PRINCIPAL MEMBER OR POLICYHOLDER

Please complete in block capitals

Last name

First names Title

Medical Insurer

Membership/ policy number

ID/ Passport number

### 2. GENERAL PATIENT INFORMATION

Please complete in block capitals

Patient's last name

Patient's first names

Patient dependant code Gender M F

Date of birth Y Y Y Y M M D D

Home telephone (please include country and area code) +

Mobile (please include country and area code) +

Fax (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

### 3. DOCTOR AND PROVIDER DETAILS

Please complete in block capitals

Treating doctor's first name

Treating doctor's last name

Speciality

Practice/Registration No.

Hospital name

Hospital Practice No.

Work telephone (please include country and area code) +

Fax (please include country and area code) +

Mobile (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

## PATIENT HISTORY

Please complete in block capitals

**Primary Diagnosis**

ICD-10 code

Primary site

Date first diagnosed Y Y Y Y M M D D

**Secondary Diagnosis**

ICD-10 code

Secondary site

Date of second diagnosis Y Y Y Y M M D D

**Performance Status**

Grade Stage: T N M ECOG scale Karnofsky score

**Metastases**

Bone Date Y Y Y Y M M D D

Brain Date Y Y Y Y M M D D

Liver Date Y Y Y Y M M D D

Lung Date Y Y Y Y M M D D

Other Date Y Y Y Y M M D D

If other, please specify

Receptors

Co-morbidities 1 2

3 4

**Prostate**

Volume Gleason scale PSA Stage

Other

## TREATMENT HISTORY

**Full Clinical History**

| Start Date | Description | Medication | Outcome | Comments |
|---|---|---|---|---|
| Y Y Y Y M M D D | | | | |
| Y Y Y Y M M D D | | | | |
| Y Y Y Y M M D D | | | | |
| Y Y Y Y M M D D | | | | |

## PROPOSED TREATMENT PLAN

**Chemotherapy Drugs**

| Product Name | Active Ingredients | Dose | Frecuency | No. of Cycles | Total Cost |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Supported Drugs**

| Product Name | Active Ingredients | Dose | Frecuency | No. of Cycles | Total Cost |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Radiotherapy**

Treating doctor

Professional practice No.

Name of Hospital

Technical/Hospital No.

Start date Y Y Y Y M M D D End date Y Y Y Y M M D D

Area to be irradiated

Duration (in weeks)

| | Tariff codes | Tariff costs | | Tariff codes | Tariff costs |
|---|---|---|---|---|---|
| 1 | | | 5 | | |
| 2 | | | 6 | | |
| 3 | | | 8 | | |
| 4 | | | 9 | | |
| 5 | | | 10 | | |

**Application Check List** (Mark with a cross the documents that are attached for submission)

- ☐ Completed Application Form
- ☐ Histology Results
- ☐ Pathological results indicating tumor markers (if applicable)
- ☐ Radiological Investigation Results
- ☐ Additional Clinical Motivation, including relevant supportive clinical literature, may be required for requests outisde of Liberty Health's funding protocols

## ACKNOWLEDGEMENT BY EXAMINING DOCTOR

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Having conducted a personal medical examination, I certify that the particulars are, to the best of my knowledge and belief, true and accurate . I acknowledge that the Insurer will rely on such particulars when making any recommendations regarding the payment of treatment and services.

Doctor's last name

Doctor's first name

Doctor's signature

Date Y Y Y Y M M D D

## 4. PATIENT'S DECLARATION

I hereby declare that the information in this form is true and correct. I am aware that the Insurer may request medical information from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires.

In order to fully assess this application for benefits, I hereby give my consent for the Insurer to obtain this information. I understand that this application is subject to the Liberty Health Cover Policy Conditions and benefits.

Patient's signature

Date Y Y Y Y M M D D