

Liberty Health Cover

Chronic Medicine Application Form



LIFE INVESTMENTS INSURANCE HEALTH PROPERTIES ADVICE

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.
- It is compulsory to complete all the fields in this form.

1. PERSONAL DETAILS | PRINCIPAL MEMBER OR POLICYHOLDER

Please complete in block capitals

First name and last name

Title Membership or policy number

2. GENERAL PATIENT INFORMATION

Please complete in block capitals

Patient's first name and last name

Title Date of birth Y Y Y Y M M D D Gender M F

3. DOCTOR AND PROVIDER DETAILS

Please complete in block capitals

Hospital name

Hospital Practice No.

Treating doctor's first name and last name

Practice/Registration No. Speciality

Work number (include country and area code) +

Mobile (include country and area code) +

E-mail

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

CLINICAL EXAMINATION GENERAL INFORMATION (TO BE COMPLETED FOR ALL APPLICANTS)

Please complete in block capitals

Weight (kg) Height (cm) BMI Smoking Y N Exercise Y N TIA/Stroke Y N

Blood pressure (sitting, having rested for 5 minutes) mmHg Date of test Y Y Y Y M M D D

Please tick the box next to the chronic condition(s) listed below that apply to your patient.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Bronchiectasis | <input type="checkbox"/> Depression | <input type="checkbox"/> Gastro-oesophageal reflux disorder (GORD) |
| <input type="checkbox"/> Addison's disease | <input type="checkbox"/> Bulimia nervosa | <input type="checkbox"/> Dermatitis/eczema | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Cardiac failure | <input type="checkbox"/> Dermatomyositis | <input type="checkbox"/> Haemophilia |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Diabetes insipidus | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Chronic obstructive pulmonary disorder (COPD) | <input type="checkbox"/> Diabetes mellitus type 1 | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Chronic renal disease | <input type="checkbox"/> Diabetes mellitus type 2 | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Anorexia nervosa | <input type="checkbox"/> Conn's syndrome | <input type="checkbox"/> Diverticular disease | <input type="checkbox"/> Hyperlipidaemia |
| <input type="checkbox"/> Arrhythmias and conduction disorders | <input type="checkbox"/> Cor pulmonale | <input type="checkbox"/> Dysrhythmias | <input type="checkbox"/> Hyperparathyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coronary artery disease/Ischemic heart disease | <input type="checkbox"/> Dystonia | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Attention deficit hyperactivity disorder (ADHD) | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Barrett's oesophagitis | <input type="checkbox"/> Cushing's disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Benign prostatic hypertrophy | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Generalised anxiety disorder (GAD) | <input type="checkbox"/> Hypopituitarism |
| <input type="checkbox"/> Bipolar mood disorder | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Malabsorption syndrome |
| | | | <input type="checkbox"/> Male hypogonadism |

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Meniere's disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Systemic lupus erythromatosus |
| <input type="checkbox"/> Menopausal and perimenopausal disorders | <input type="checkbox"/> Paget's disease | <input type="checkbox"/> Psoriatic arthritis | <input type="checkbox"/> Thrombosis and embolism |
| <input type="checkbox"/> Menorrhagia | <input type="checkbox"/> Paralytic syndromes and associated complications | <input type="checkbox"/> Pulmonary interstitial fibrosis | <input type="checkbox"/> Tourette's syndrome |
| <input type="checkbox"/> Motor neuron disease | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Transient ischaemic attacks |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Pemphigus | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Trigeminal neuralgia |
| <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Polyarteritis nodosa | <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Myasthenia gravis | <input type="checkbox"/> Polycystic ovarian syndrome | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Polymyalgia rheumatica | <input type="checkbox"/> Scleroderma and systemic sclerosis | <input type="checkbox"/> Urinary tract infection (chronic) |
| <input type="checkbox"/> Obsessive compulsive disorder (OCD) | <input type="checkbox"/> Post-traumatic stress disorder | <input type="checkbox"/> Sicca syndrome | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Primary/idiopathic thrombocytopaenic purpura | <input type="checkbox"/> Stroke | <input type="checkbox"/> Zollinger-ellison syndrome |

Other Date of diagnosis

In order to register patients on the Chronic Medicine Programme, documentation from a relevant specialist and/or test results verifying the diagnosis, is required for the following:

Diabetes:

HbA1C mmol/l

HGT m.mg

Date of diagnosis

Date of tests done

Date of tests done

Hyperlipidaemia:

TC

HDL

TG

LDL

Date of diagnosis

Date of tests done

Date of tests done

Date of tests done

Please complete the following table with the required details of your patient's current chronic medication prescription. Or attach a copy of your patient's latest medicine prescription when you submit this form.

Diagnosis/ ICD-10 code	Active ingredients	Medicine trade name	Strength (e.g. 10mg)	Directions (e.g. lts)

Special investigagions/ motivations

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(s)

Doctor's signature

Date

PATIENT'S DECLARATION

I am aware that the Insurer may request relevant medical information from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires to make an appropriate funding decision about my care.

In order for the Insurer to fully assess this application for benefits, I hereby give my consent for them to obtain this information from the relevant healthcare provider. I further understand that this application is subject to the Liberty Health Cover Policy Conditions, available benefits and relevant funding protocols.

Patient's signature

Date