Liberty Health Cover Oncology Application Form



LIFE INVESTMENTS INSURANCE HEALTH PROPERTIES ADVICE

Important: please rea • Please write clearly u							ting	this	appl	icatior	ı for	m	• Ple	ease	subr	nit yo	our c	omp	leted	l forn	n to c	our L	ibert	ty He	ealth	Cove	er in-	coun	itry	
1. PERSONAL DE	TAILS	PRI	NCII	PAL	MEI	MBE	RO	R P	OLIC	CYHO	LDI	ER																		
Please complete in blo	ck capit	als																												
First name and last na	ame																													
Title				Me	mbei	rship	or p	olicy	nun	ber																				
2. GENERAL PAT	IENT	INFO	RM <i>A</i>	ATIO	N																									
Please complete in blo																														
Patient's first name a	nd last	name																												
Title								I	Date	of birt	:h	Υ	Υ	Υ	Υ	М	M	D	D							Gen	der	M		F
3. DOCTOR AND	PROV	'IDER	DE	TAIL	.S																									
Please complete in blo	ck capit	als																												
Hospital name																														
Hospital Practice No.																														
Treating doctor's first	name	and la	st na	me																										
Practice/Registration	No.													Sp	ecia	lity											Ī			
Work number (includ	le coun	try an	d are	a coc	de)	+					Ì														T		T			$\overline{}$
Mobile (include coun	try and	area d	code))		+																								
E-mail																											T			
TO BE COMPLETED		IE ATT	END	ING	MED	ICAL	. PR/	ACTI	ΓΙΟΝ	IER																				
PATIENT HISTOR																														
Please complete in blo Primary Diagnosis	ck capit	als																												
ICD-10 code										Primar	ry si	te																		
Date first diagnosed	Υ	YY	Υ	М	M	D	D					,																		
Secondary Diagnosis	5							J																						
ICD-10 code									Se	condar	ry si	te																		
Date of second diagn	osis	YY	Y	Y	M	M	D	D																						
Performance Status																														
Grade			Stage: T						N			М				ECO	G sc	ale					Karr	nofsk	y sc	ore				
Metastases									,			,																		
Bone	Date	e Y	Υ	Υ	Υ	M	M	D	D							Br	ain				Da	ate	Υ	Υ	Υ	Υ	M	M	D	D
Liver	Date	e Y	Υ	Υ	Υ	M	M	D	D							Lu	ıng				Da	ate	Υ	Υ	Υ	Υ	М	M	D	D
Other	Date	e Y	Υ	Υ	Υ	M	M	D	D																					
If other, please specif	y																													
Receptors																														
Co-morbidities		1														2														
		3														4														
Prostate																												1		
Volume						G	leaso	on sc	ale						F	PSA								Sta	age					
Other																														

TREATMENT HIST	ORY																												
Full Clinical History								1																					
Start Date		Description									Outcome								Comments										
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Y Y Y W M D E																													
PROPOSED TREAT	MEN	T PL	AN																										
Chemotherapy Drugs																													
Product Name		Α	ctive	e Ing	redie	ents)ose						Freq	uen	су				No.	of C	ycle	s		Tot	al Co	st
Supportive Therapy																													
Product Name		Α	ctive	e Ing	redie	ents			Γ	ose						Freq	uen	су				No.	of C	ycle	s	Total Cost			
Radiotherapy																													
lame of radiologist																													
Professional practice N	0.																												
Name of Hospital																													
echnical/Hospital No.																													
start date Y Y	Y	M	M	D	D			End	date	Υ	Υ	Υ	Υ	M	M	D	D												
Area to be irradiated																													
Ouration (in weeks)																													
Tariff codes				7	Tariff	cost	ts										Tar	iff co	des						Tarif	fcos	S		
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										7																			
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4															9														
5															10														
Application Check List	: (Mark	with	a cr	oss t	he do	ocur	nents	that a	re atta	ache	d for	subr	nissio	on)							_								
Completed Appli	cation	Form										His	stolo	gy R	esul	S													
Pathological resu	lts indi	cating	g tun	nour	marl	kers	(if ap	plicabl	e)			Ra	diolo	gica	l Inv	estig	ation	า Res	sults										
Additional Clinica	l Motiv	atior	n, inc	ludir	ng rel	levar	nt su	portiv	e clini	cal lit	erat	ure, i	may	be re	equir	ed fo	or red	ques	ts ou	ıtsid	e of l	_iber	ty H	ealth	ı's fu	ındin	g pro	otoco	ols
ACKNOWLEDGEM TO BE COMPLETED BY									D																				
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hat the Insurer will rely																												8	
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4. PATIENT'S DECLARATION

I am aware that the Insurer may request relevant medical information make an appropriate funding decision about my care.	from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires to
, 11	ereby give my consent for them to obtain this information from the relevant healthcare perty Health Cover Policy Conditions, available benefits and relevant funding protocols.
Patient's signature	Date Y Y Y M M D D