Medical eligibility declaration

Health Care Insurance

To be eligible to claim for certain appliances, aids and medications, you need to provide us with certification from your medical doctor or specialist. Please see our website for details of this requirement before completing and returning the following form with the relevant receipt.

You can return your completed form and related receipts to us via the submit document section of OMS or by emailing it to enquiries@hciltd.com.au.

Member details

Member number

Family name

Given name(s)

Postal address (including postcode)

Email

Mobile

Date of birth

dd / mm / yyyy

Please let us know of any new address details via OMS (Online Member Services) or calling us.

Is this claim related to a Workers Compensation, WorkCover third party insurance or other claim? ◯ Yes ◯ No If yes, please complete the **HCi Claims declaration** instead.

Electronic Funds Transfer (EFT) details

Complete the following only if you have not given us your account details or you want to change the details currently recorded for you.

Do you wish this to be the permanent credit details for your policy? ◯ **Yes** (The policyholder or authorised person must sign this form.) ◯ **No**

Name of account holder

BSB number

Account number

Member declaration

◯ I declare that I have not claimed this aid, appliance or medication from any other source

◯ I confirm that the purchased item was purchased new (ie not second hand) from an Australian supplier.

◯ I declare the above information and any attachments to be true and correct to the best of my knowledge, and that any attached receipts are a true copy of the original.

◯ I authorise HCi to contact all relevant medical practitioners and/or suppliers for information required to process this claim.

◯ I understand that HCi will only pay this claim if my membership is current and I am fully eligible for the purchased item(s).

◯ I understand that this form will expire 12 months from my medical provider's declaration date; from then, a new form will have to be completed to continue to receive any benefits.

Member's signature

Date

dd / mm / yyyy

Medical practitioner details

To be completed by your medical practitioner.

Practitioner name

Provider number

Practice name

Phone number

Postcode

dd / mm / yyyy

Appliance / aid details

To be completed by a suitably qualified medical practitioner.

I am a ○ GP ○ Physiotherapist ○ Chiropractor ○ Psychologist ○ Podiatrist ○ Osteopath

○ Other (please specify)

What aid, appliance or medication are you prescribing for the above-named patient?

What specific medical condition will be assisted by the use of this aid, appliance or medication? Please see our website for details of required information.

What timeframe, including any previous years, does this recommendation cover?

Medical practitioner declaration

☐ I declare that the above-named patient is in my care and that the listed aid, appliance or medication is required to manage the specific condition listed above.

☐ I declare the above information to be true and correct to the best of my knowledge.

Practitioner's signature

Date

dd / mm / yyyy