LIBERTY

In it with you

Liberty Health Cover Chronic Medicine Application Form

Important: please read the following before completing this application form

- Please write clearly using capital and block letters.
- It is compulsory to complete all the fields in this form.
- 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

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.

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

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

Other _____ Date of diagnosis Y Y Y Y M M D D

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: Date of diagnosis Y Y Y Y M M D D

HbA1C ____ mmol/l Date of tests done Y Y Y Y M M D D

HGT ____ m.mg Date of tests done Y Y Y Y M M D D

Hyperlipidaemia: Date of diagnosis Y Y Y Y M M D D

TC ____ Date of tests done Y Y Y Y M M D D

HDL ____ Date of tests done Y Y Y Y M M D D

TG ____ Date of tests done Y Y Y Y M M D D

LDL ____ Date of tests done Y Y Y Y M M D D

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. 1tds)

Special investigations/ 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 Y Y Y Y M M D D

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 Y Y Y Y M M D D