LIBERTY

In it with you

Liberty Health Cover Oncology Application Form

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

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

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 | Lung | Date

Other | Date

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	Frequency	No. of Cycles	Total Cost

Supportive Therapy

Product Name	Active Ingredients	Dose	Frequency	No. of Cycles	Total Cost

Radiotherapy

Name of radiologist

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			6		
2			7		
3			8		
4			9		
5			10		

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

- ☐ Completed Application Form
- ☐ Pathological results indicating tumour markers (if applicable)
- ☐ Histology Results
- ☐ Radiological Investigation Results
- ☐ Additional Clinical Motivation, including relevant supportive clinical literature, may be required for requests outside 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 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