

Liberty Health Cover Medical Questionnaire

| 1. PERSONAL DETAILS OF PRINCIPAL MEMBER Last name First name(s) Initials 2. PERSONAL DETAILS OF PATIENT Last name First name(s) Initials Date of birth 3. MEDICAL INFORMATION REQUIRED | | | | | | | Title | | | | | |
|---|-----------|----------|--------|-------|------|--------|-------|---|---|---|---|---|
| Last name First name(s) Initials Date of birth | | | | | | | Title | | | | | |
| 3. MEDICAL INFORMATION REQUIRED | | | | | | | | | | | | |
| TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER a. Name of medical condition/s: | | | | | | | M | M | Y | Y | Y | Y |
| b. What date did you first consult with the patient for this condition/symptom? c. Please confirm the date of your first treatment or recommended treatment for this condition? d. Please confirm the date the patient first presented with symptoms for this condition? e. Please confirm the date of diagnosis for this condition? | ition/syı | mptom | | | | | M | M | Υ | Υ | Υ | |
| f. Do you know if the patient consulted with any other healthcare provider prior to the first of g. If yes, please provide the relevant healthcare provider's contact details Provider's first name Provider's last name | consulta | ation wi | th you | about | this | condit | ion? | | | | Υ | N |
| Providers work number (include country and area code) + Provider's mobile (include country and area code) + Provider's Email | | | | | | | | | | | | |
| If yes to question f., what treatment did this healthcare provider recommend for the condition | 1/5: | | | | | | | | | | | |

| | | | | | | | | | CTI | FLON | ED | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|---|---|--|----------------------------|--|--|---|---------------------------|--|---------------------------------|--|---|-------------------------------|------------------------------|---|--------------------------------------|---------------------------|-------------------------|
| ACKNOWLEDGEMEN | IT BY | ΑTΊ | ENI | OIN | G M | EDI | CAL | PRA | CIII | IION | EK | | | | | | | | | | | | | | | | |
| TO BE COMPLETED BY T | IE ATT | ΓΕΝΙ | DING | ME | DIC | AL PI | RACT | ITIOI | NER | | | | | | | | | | | | | | | | | | |
| I confirm that the informat | ion pro | ovide | ed in | this | ques | stion | naire, | is tru | ue, co | orrect | and c | ompl | ete ar | nd that | I hav | e no | with | held, | con | ceal | ed or | miss | state | d any | info | rmati | on. |
| Provider's last name | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider's first name(s) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | ' | | Υ | Υ | Υ | Υ | M | VI | D | D | | | | ' | | |
| Provider's signature | | | | | | | | | | | | | Date | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A DECLADATION BY T | IE DA | TIF | NIT/E | | VICIE | 241 | B 4 E B 4 | IDEE | | | | | | | | | | | | | | | | | | | |
| I. DECLARATION BY TI | 1E PA | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a 1.4 1 1 .4 | | | | | | | | | | | | 16.1 | | | | | | | | | | | | | | | |
| | below, | | | | | | | | | ature | below | v. If th | ne pat | ient is | a min | or, th | nis se | ction | shou | ıld b | e com | nplet | ted b | y the |) | | |
| Principal Member. | e neces | the ssary | n pro | vide | e you | ır full | name | e and | sign | | | | | | | | | | | | | • | | • | | resp | ect |
| Principal Member. a. I confirm that I have the of my nominated depe | e neces ndant(mation | ssary s). | n pro | ovide noris | you ation | ir full | disclo | e and ose th | sign ne inf | orma | tion th | nat th | e Insu | urer ma | ay req | uire a | and p | rovid | e the | e ned | cessar on, is | ry au true | ithor | isatio | ons in | ompl | ete |
| Principal Member. a. I confirm that I have the of my nominated depe b. I confirm that the infor and that I have not with health insurance. | e neces ndant(mation sheld, c any n tus to t | ssary s). proconc | n pro vauth video ealeo cal pro | ovide noris d in t d or r racti | e you this a misst | or full ons to epplicated er, he | discloration | e and ose th , and nforn al, me tracte | sign ne inf l in ar natio | ormany oth | tion the ner doo luding itution nsurer | cume gany i | e Insuents suinforn | urer maubmitte | ed in state | uire a supp he In | and port or sure | f this a shou | e the appl Id ki | e ned icati now n ab | cessar on, is to ass out n | ry au true sess | thor , cor my e | isation rect a ligibil or m | ons in and ca lity to ay no | ompl rece | ete ive |
| Principal Member. a. I confirm that I have the of my nominated depe b. I confirm that the infor and that I have not with health insurance. c. I irrevocably authorise dependants' health sta and I agree that this au | e neces ndant(mation theld, c any n tus to t thorisa to colle | , the ssary s). i pro conc he li ition ect, prer ii | n pro vauth video ealeo cal prosure shall proce n ord | noris d in t d or r racti er or l rem | e you sation this a misst ition any e nain i | ns to applicated er, ho entity n for hare | discloration any in cospita y confice aft my pe funct | e and ose th i, and inforn inforn ions, | I sign ne inf I in a natic ed by y/the nal in duti | ormany oth on, inc othe li othe li eir dea forma es and | ner doo luding itution nsurer ath(s). ation a | cume gany i n, or in or nd th | ents suinforn other der to | ubmitte nation perso ofulfilit any no erms o | ed in state of the total and total a | uire a supp he In disclo | ort or surei ose in | f this a shou nform ties a | e the applid kind of ordination | e neo icationow n ab bliga with | cessar on, is to ass out nations | true sess ny o in to | , cor my e wn, erms | isation rect a ligibil or m of th | and collity to | omplorece mina reem | ete ive ed ent |
| Principal Member. a. I confirm that I have the of my nominated depe of the confirm that the informand that I have not with health insurance. b. I irrevocably authorised dependants' health stand I agree that this aud. I authorise the Insurer entity, contracted by the force after my/their de | e neces ndant(mation theld, c any n tus to t thorisa to colle | , the ssary s). i pro conc he li ition ect, prer ii | n pro vauth video ealeo cal prosure shall proce n ord | noris d in t d or r racti er or l rem | e you sation this a misst ition any e nain i | ns to applicated er, ho entity n for hare | discloration any in cospita y confice aft my pe funct | e and ose th i, and inforn inforn ions, | I sign ne inf I in a natic ed by y/the nal in duti | ormany oth on, inc othe li othe li eir dea forma es and | ner doo luding itution nsurer ath(s). ation a | cume gany i n, or in or nd th | ents suinforn other der to | ubmitte nation perso ofulfilit any no erms o | ed in state of the total and total a | uire a supp he In disclo | ort or surei ose in | f this a shou nform ties a | e the applid kind of ordination | e neo icationow n ab bliga with | cessar on, is to ass out nations | true sess ny o in to | , cor my e wn, erms | isation rect a ligibil or m of th | and collity to | omplorece mina reem | ete ive ed ent |
| b. I confirm that the infor and that I have not with health insurance. c. I irrevocably authorise dependants' health sta and I agree that this au d. I authorise the Insurer entity, contracted by the | any ntus to the thorisation collections at the second at t | the ssary s). I proconce hedication ect, pre iii and i | n provided authorised processing ordered processing ordere | d in the raction of t | e you sation this a misst ition any e anain i nd sh | ns to applicated er, ho entity n for hare fil its | discloration discl | e and ose the nform al, me tracte er my erson ions, y par | I sign ne inf I in an natic edica ed by y/the nal in duti tially | ny oth n, inc I insti the li eir dea forma es and | ner doo luding itution nsurer ath(s). ation a d oblig my/th | cume gany i n, or i in or nd th gation neir ri | e Insu | person fulfilling any no erms of privace | ed in s that t n to c ts fun minat f this | supp he In disclor ction ted d | ort or ort or surei | f this a r shou nform ties a ddants nt, agr | e the applid kind of ordination | e neo icationow n ab bliga with | cessar on, is to ass out nations | true sess ny o in to | , cor my e wn, erms | isation rect a ligibil or m of th | and collity to | omplorece mina reem | ete ive ed ent |
| Principal Member. a. I confirm that I have the of my nominated depe b. I confirm that the infor and that I have not with health insurance. c. I irrevocably authorise dependants' health sta and I agree that this au d. I authorise the Insurer entity, contracted by the force after my/their de | e necessindant(mation mation held, c any n tus to t thorisa to colle ne Insu math(s) a | the ssary s). I proconconediche lution rer ii and i | r auth video ealeo cal prosure shall proce n ord unde | d in to do noris | e you sation this a misst ition any e anain i nd sh o fulf and th | ns to applicated er, hoe entity in for hare fil its actit | discloration any in any posterior after a function and in any posterior after a function and in any posterior and in any any posteri | e and ose th i, and inform al, me tracte eer my erson ions, yy par to pr | I sign ne inf I in a natic edica edica ed by y/the duti tially | ny oth n, inc I insti t the li eir dea forma s and limit | ner doo diluding itution nsurer ath(s). attion a d oblig my/th | cume gany i n, or in or nd th gation neir rig | e Insu | person fulfilling on any no erms of privace on any no erms of privace on any notation and the second of the second on any notation and the second on any no | ed in s that t n to o ts fun minat f this cy. | uire a supp he In disclor cction ted d agre | ort or surei | f this a shou | e the applid kind of ordination | e need ication | cessar on, is to ass out nations | true sess ny o in to | , cor my e wn, erms | isation rect a ligibil or m of th | and collity to | omplorece mina reem | ete ive ed ent |