OVHC Pre-Existing Ailments Certificate

Form A
GP/Other

Why you need to complete this form: When you've been, or are about to go into hospital whilst within waiting periods, nib needs information about the procedure to determine if you're covered.

Important: Your doctor/s need to complete part of this form, and you might incur a charge for the consultation. Unfortunately, if you're charged, you can't claim these costs with the health insurer.

Please note: A condition can still be classed as pre-existing even if a patient has not seen a doctor about it before joining their hospital policy or upgrading to a higher hospital policy.

Please take care
completing this form as it is a legal document and any later changes will only be accepted in exceptional circumstances with documented evidence to accompany the alterations.

General details

Member number

Member name

Patient name

Date of birth

Address

Suburb

State **Please select**

Postcode

Your consent – by the patient/guardian for disclosure of information by their doctor to the health insurer

I authorise all medical practitioners whom I consulted for the ailment, illness or condition in question to provide the health insurer with any personal and medical information relating to my medical history and any other information that may be required for the purpose of assessing this claim.

Patient/Guardian signature

Date

Certification by Medical Practitioner

1. Are you the patient's: ☐ General Practitioner ☐ Referring Doctor/Other (please specify)

2. How long have you been the patient's Medical Practitioner?

3. Date of FIRST consultation for this condition/ailment

4. Signs/symptoms consisted of

5. Signs/symptoms had been present for ☐ Days ☐ Weeks ☐ Months ☐ Years

6. Has the patient ever suffered from an episode of similar symptoms or has this diagnosis been made in the past?

7. Specialist's name if you referred the patient

8. Date of referral (please attach a copy of the referral letter with this certificate)

Declaration

I hereby certify that the above details are true and correct

Doctor's signature

Doctor's stamp

Doctor's name

Doctor's phone number (practice)

Date

Please return your completed form via

Mail: **Reply Paid 62208, Locked Bag 2010, Newcastle NSW 2300**

Email: **illnessandevidence@nib.com.au**

OVHC Pre-Existing Ailments Certificate

Form B
Specialist

Why you need to complete this form: When you've been, or are about to go into hospital whilst within waiting periods, nib needs information about the procedure to determine if you're covered.

Important: Your doctor/s need to complete part of this form, and you might incur a charge for the consultation. Unfortunately, if you're charged, you can't claim these costs with the health insurer.

Please note: A condition can still be classed as pre-existing even if a patient has not seen a doctor about it before joining their hospital policy or upgrading to a higher hospital policy.

Please take care
completing this form as it is a legal document and any later changes will only be accepted in exceptional circumstances with documented evidence to accompany the alterations.

General details

Member number

Member name

Patient name

Date of birth

Address

Suburb State **Please select** Postcode

Your consent – by the patient/guardian for disclosure of information by their doctor to the health insurer

I authorise all medical practitioners whom I consulted for the ailment, illness or condition in question to provide the health insurer with any personal and medical information relating to my medical history and any other information that may be required for the purpose of assessing this claim.

Patient/Guardian signature

Date

Certification by Medical Practitioner

1. Date of hospital admission (or proposed admission)

2. Name of hospital

3a. Principal condition (reason for hospitalisation)

3b. Nature of operation (if any)

3c. Procedure item number/s

4. Date patient FIRST consulted you regarding this condition

5. Signs/symptoms consisted of

6. Signs/symptoms had been present for

Days Weeks Months Years

7. Has the patient ever suffered from an episode of similar symptoms or has this diagnosis been made in the past?

8. Who referred the patient to you?

9. Date of referral (please attach a copy of the referral letter with this certificate)

Declaration

I hereby certify that the above details are true and correct

Doctor's signature

Doctor's stamp

Doctor's name

Doctor's phone number (practice)

Date

Please return your completed form via

Mail: **Reply Paid 62208, Locked Bag 2010, Newcastle NSW 2300**

Email: **illnessandevidence@nib.com.au**