NATIONAL PRIVATE PATIENT HOSPITAL CLAIM FORM

Private Health Fund | Hospital

Hospital Provider Number | Hospital Record Number

1. PATIENT / FUND MEMBERSHIP DETAILS (Please print and insert ticks (✓) in boxes)

Family Name of Patient | Mr/Mrs/Miss/Ms

Given Names of Patient

Membership Number | Level of Cover

Relationship of Patient to Member | Patient's Date of Birth / / | Age

Family Name of Member | Mr/Mrs/Miss/Ms

Given Names of Member

Residential Address of Member

Postcode

Is this a permanent address? Yes ☐ No ☐ Email

Telephone: Home ( ) Work ( ) Mobile

Adding a newborn child to your family membership: Sex | Date of Birth / /

Family Name | Given Names

Full name of Admitting Medical Practitioner:

2. DECLARATION CONCERNING CLAIM (The accurate answers to these questions are an essential part of this claim)

Patient/Guardian to complete (please tick (✓) below)	**Yes**	**No**
Do you have entitlement to claim compensation or damages (including previous settlements)?	☐	☐
Have you lodged a claim for compensation or damages?	☐	☐
Did the injury or condition occur at work, going to or from work or as a result of being at work?	☐	☐
Did the hospitalisation result from a motor vehicle accident?	☐	☐
Did the hospitalisation result from any other type of accident?	☐	☐
Does the patient have an entitlement to free treatment under Australian Veterans' legislation?	☐	☐
Is the patient a full-time student dependant over 17 years and under 25 years?	☐	☐

If yes, name of educational institution:

Date patient was first aware of symptoms: / / Date patient first consulted a doctor for symptoms: / /

Were the financial implications of your hospital charges explained prior to admission? ☐ ☐

Have you signed an Election Form to elect to be treated as a private patient? (PUBLIC HOSPITAL PATIENTS ONLY) ☐ ☐

☐ **I hereby declare and warrant that all the above information provided in connection with this claim is true and correct.**

☐ **I authorise the hospital, or any other authorities concerned with this hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all information, including Hospital Casemix Protocol information as required by the Federal Government, to the private health fund for the purpose of providing private health insurance in accordance with the fund's privacy policy.**

☐ **I authorise my health fund to pay benefits directly to the hospital.**

Patient's/ Guardian's Signature: **Date:** / /

3. HOSPITAL ACCOMMODATION DETAILS (To be completed by Hospital: please see overleaf for codes.)

Admission Date: / / Separation Date: / /

Admission Code	Accomm. Code	Date From	Date To	Discharge Code	Days Claimed	Payment Type Code	Amount Charged
						☐ Other:	
						☐ Other:	
						☐ Other:	
						☐ Other:	

Same Day Patients Only (Please tick (✓) boxes below)

Admission Time (24hr) : | Separation Time (24hr) : | Same Day Band (1-4)

Anaesthetic: None ☐ Local ☐ Intravenous ☐ Regional ☐ General ☐

Time in Theatre (ALL EPISODES – 24 hr)

From : To :

From : To :

From : To :

Theatre/MBS (*Principal MBS first)

MBS Item	Date of Service	Amount Charged
*		

Other Services

Code	Date of Service	Number	Amount Charged

Certificates Attached:

Please tick (✓): Acute ☐ Psych. ☐ Rehab. ☐ ICU ☐ NICU ☐ Pt. Election ☐

Same Day Certification

☐ (See Section 4 overleaf)

Diagnoses / Procedures / Other Details

DRG | DRG VERSION | PRINCIPAL DIAGNOSIS ICD-10-AM

Additional Diagnoses ICD-10-AM					
Procedure Codes ICD-10-AM (*Principal Procedure first)	*				
Infant/Neonate Weight	Age in Days	Urgency of Admission	Mode of Separation	Source of Referral	Transfer In
Care Type	Non-Acute Length of Stay	Total Leave Days	ICU Hours	MV Hours	Transfer Out
Same Day Status	Mental Health Legal Status	Inter-Hospital Contracted Patient	Unplanned Theatre Visit During Episode: Yes ☐ No ☐	Provider No. of Hospital Transferred From:	Provider No. of Hospital Transferred To:

I certify the above information is true and correct according to our records for this period of hospitalisation. The hospital authorises the fund or its agent to inspect all records applicable to the patient for the purpose of determining appropriate benefits.

Authorising Hospital Officer's Signature: **Date:** / /

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