INSULIN PUMP REPLACEMENT FUNDING FORM

Please ask your GP or Specialist to complete this form if you've received an insulin pump replacement outside of a hospital.

You should check your eligibility for this benefit with us prior to completing the form, so please call us on 134 246.

Once completed, please return this form with the invoice or receipt attached for processing to:

ahm, Locked Bag 1006, Matraville NSW 2036.

Patient's Name: ______________________________

Date of Birth: ______________________________

ahm Membership No: ______________________________

Details of your GP/Specialist:

GP/Specialist Name: ______________________________

Contact Number: ______________________________

Address: ______________________________

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Prostheses List Code: ______________________________

I confirm that the provision of this insulin pump replacement is medically necessary, that the prosthesis is included on the Department of Health & Ageing Prosthesis List as at the date of service and that the pump being replaced is not within warranty.

GP/ Specialist Signature: ______________________________ Date: ______________

Member/ Guardian Declaration

I declare that the information on this form is true and correct. I authorise ahm to check any of these services with the relevant prosthesis supplier or medical practitioner and if benefits have already been paid by previous health insurers. I acknowledge that ahm may use the information on this claim to assess and process this claim, or for purposes related to this claim as outlined in the ahm Privacy Policy. I confirm that the services submitted on this claim form were performed by the providers, and received by the persons named on this form. I authorise ahm to contact the prosthesis supplier or medical practitioner in relation to the payment of the insulin pump invoice if required.

Member /Guardian Signature: ______________________________ Date: ______________

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