

Section 13: Fast Cover Medical Certificate

This medical certificate is to be completed:

- at the claimant's expense
- by the patient's usual Doctor or Dentist in Australia
- for all cases of medical, dental, unexpected expense and cancellation claims resulting from an accident, illness, disability or death.

The medical practitioner is respectfully requested to give as much detail as possible in order for us to assist our client and avoid the necessity of additional enquiries

Claim Number:

Claimants Name:

1. Patients Name:

Patients Date of Birth:

2. Are you the Patients usual GP?

Yes No

2A. If yes, how many years/months?

2B. If no, please give details of the Patients usual GP:

3. What is the precise diagnosis of the injury or illness that led to this claim?

4. Date of onset of injury or illness:

5. Date you were first consulted for this injury or illness:

5A. What test(s) did you prescribe?

5B. Date test(s) prescribed:

5C. Date test(s) performed:

5D. Date results advised to Patient:

6. Was the Patient under the care of any other Doctors, including Specialists?

Yes No

6A. If yes, please provide the details of the other treating Doctors:

6B. Date first referred to a Specialist:

6C. Name of Specialist/Surgeon:

6D. Phone number of Specialist/Surgeon:

6E. Email of Specialist/Surgeon:

6F. Postal address of Specialist/Surgeon:

7. Have you previously treated or advised this patient in respect of the same illness or injury as described in question 3?

7A. If yes, please provide details below:

7B. If yes to '7' was this illness/injury the same or a similar/related injury? Yes No

7C. If yes to '7', please state when you last treated the patient, prior to the occurrence giving rise to this claim, and give details of the treatment and/or medication prescribed:

7D. If yes, was the patient advised to continue this treatment and/or medication:

Until departure on the Trip Yes No

Whilst on the Trip? Yes No

8. Did the Patient travel against your advice? Yes No

9. Are you prepared to certify that the Claimant(s) were required to cancel their travel arrangements solely due to the condition described in question 3? Yes No

10. Please attach your consultation notes relevant to this condition described in question 3

I certify that the Statements contained in this medical certificate are true and correct.

Doctors Name:

Doctors Signature:

Qualification:

Phone:

Fax:

Email:

Address:

Suburb:

State:

Postcode:

Please return completed form to Fast Cover

Email Address claims-fch@fastcover.com.au (Please include claim number in email subject)

Phone Number 1300 409 322

Fax Number 02 8883 7002

Postal Address Fast Cover Claims
Locked Bag 2010
St Leonards NSW 1590

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